Supreme Court, U.S.
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No. 03-

In the Supreme Court of the United States

RELIANCE STANDARD LIFE INSURANCE COMPANY, PETITIONER

v.

STEPHEN P. LASSER

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether and to what extent, in an action challenging the denial of benefits under an insurance policy covered by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, a court must afford deference to an insurer's decision to deny benefits when the plan expressly gives the insurer the discretionary authority to determine eligibility, but the insurer is operating under a conflict of interest.

2. Whether an insurer may consider evidence that a claimant has returned to work in determining whether the claimant is "disabled," and therefore entitled to receive benefits under a long-term disability-insurance policy subject to ERISA.

STATEMENT PURSUANT TO RULE 29.6

Reliance Standard Life Insurance Company is a wholly owned subsidiary of Reliance Standard Life Insurance Company of Texas, which in turn is a wholly owned subsidiary of Delphi Financial Group, Inc. Delphi has no parent corporation, and no publicly held company owns 10% or more of its stock.

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INTRODUCTION

Almost every Term in recent years, this Court has had occasion to focus on fundamental questions concerning the preemptive effect of the Employee Retirement Income Security Act (ERISA). In those cases, this Court has painstakingly considered, and where necessary confined, the substantive reach of federal law governing employee benefit plans. At the same time, however, this Court has provided little guidance on how the lower courts should go about the frequently recurring (and vital) task of reviewing the administration of benefits under plans that indisputably fall within ERISA's broad reach. The upshot is growing disarray in the federal courts in the interpretation of ERISA.

This case presents an excellent opportunity for the Court to provide sorely needed guidance on this bread-and-butter task regularly confronting federal judges. It involves a challenge to the denial of benefits under an ERISA-covered disability-insurance policy that expressly conferred discretion on the insurer to determine whether a claimant was disabled. In overturning the insurer's decision that the claimant was not disabled, the Third Circuit, over Judge Garth's dissent, effectively applied *de novo* review. Not only is that approach inconsistent with earlier decisions of this Court and other circuits, it threatens to transform federal challenges to supposedly discretionary ERISA eligibility determinations into time-consuming and costly "battles of the experts."

Compounding its initial error, the Third Circuit, again over Judge Garth's dissent, rejected the insurer's reliance on evidence that the claimant had actually returned to work in determining whether the claimant was "disabled." That holding deepens the tension among the circuits on the issue, and threatens to undermine the basic premise of long-term disability insurance by allowing claimants to recover benefits as a supplement to, rather than replacement for, their regular income.

The resulting instability and confusion in the burgeoning law of ERISA cries out for this Court's attention. Congress' overriding objective in enacting that important statute was to establish a "uniform administrative scheme" for the disbursement of benefits nationwide. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). That vital policy goal is being subverted in the proliferation of ERISA-related litigation. Because both issues routinely recur in the federal courts, certiorari should be granted.

OPINIONS BELOW

The Third Circuit's opinion is reported at 344 F.3d 381 and reprinted in the appendix ("App.") at 5a-34a. The order denying the petition for rehearing by the panel and rehearing *en banc*, including Judge Garth's dissent from the denial of panel rehearing, is unreported and is reprinted at App. 1a-4a. The district court's first opinion, denying summary judgment to both parties, is reported at 130 F. Supp. 2d 616 and reprinted at App. 78a-104a. The district court's second opinion, entering judgment for respondent, is reported at 146 F. Supp. 2d 619 and reprinted at App. 35a-77a.

JURISDICTION

The Third Circuit entered judgment on September 18, 2003. Petitioner timely filed a petition for rehearing by the panel and rehearing *en banc*, which was denied on October 22, 2003. On January 5, 2004, Justice Souter extended the time for filing this petition until February 19, 2004. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

PERTINENT STATUTORY PROVISIONS

In relevant part, 29 U.S.C. § 1132 states as follows:

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

STATEMENT

1. Respondent Stephen P. Lasser is an orthopedic surgeon. *See* App. 5a. During the relevant time period, he was employed by Townsquare Orthopedic Associates, a four-doctor practice group in New Jersey. *See id.* In 1986, Dr. Lasser underwent heart-bypass surgery. *See id.* at 6a. Unfortunately, it was subsequently discovered that his surgery had been improperly performed. *See id.*

In July 1996, Dr. Lasser suffered a minor heart attack. *See id.* at 6a, 32a. Dr. Lasser's personal physician, Dr. Robert Aldrich, advised him to change his diet, exercise more, and reduce stress, and prescribed a drug-treatment regimen. *See id.* at 6a. In September 1996, Dr. Lasser returned to work. *See id.* He decreased his patient load and stopped performing on-call duties and conducting emergency surgery. *See id.* During this period, Dr. Lasser was earning between $4,000 and $6,000 per month, or approximately between $48,000 and $72,000 per year. *See id.* at 12a.

Petitioner Reliance Standard Life Insurance Company provided long-term disability insurance to Dr. Lasser. *See id.* at 5a-6a. Under that policy, a claimant is "disabled," and thus entitled to benefits, if he or she is not "capable of performing the material duties of his/her regular occupation" on a full-time basis. *Id.* at 42a. On December 26, 1996, Reliance approved Dr. Lasser's application for long-term disability benefits, notwithstanding Dr. Lasser's partial return to work. *See id.* at 6a. During that period, Dr. Lasser received approximately $6,000 per month, or approximately $72,000 per year, in disability benefits. *See id.* at 29a. In December 1997, however,

following a routine periodic review of Dr. Lasser's condition, Reliance concluded that Dr. Lasser was not in fact "disabled" as that term is defined in Reliance's policy, and therefore terminated his benefits. *See id.* at 6a. In so deciding, the insurer primarily relied on a medical evaluation by its independent examining physician, Dr. William Burke, who concluded, after conducting a treadmill test and reviewing results from an earlier treadmill test, that Dr. Lasser "does not demonstrate any cardiovascular difficulty." *Id.* at 15a. Under guidelines from the New York Heart Association, Dr. Burke classified Dr. Lasser in Functional Class I (referring to "[p]atients with cardiac disease but with no limitation of physical activity") and Therapeutic Class A (referring to "[p]atients with cardiac disease whose physical activity need not be restricted"). *Id.* at 16a & n.8. A nuclear cardiologist, Dr. Christos Christou, reviewed a planar image of Dr. Lasser's heart, conducted during cardiovascular testing, and concluded that Dr. Lasser suffered from only a "very small and probably clinically insignificant" heart defect, ostensibly from the improperly performed bypass procedure. *Id.* at 15a-16a.

Dr. Lasser subsequently resumed performing on-call duties and conducting emergency surgery. *See id.* at 7a, 20a. Dr. Lasser also invoked Reliance's administrative appeal procedures. *See id.* at 6a. In April 1999, after obtaining two additional medical opinions, and relying on the fact that Dr. Lasser had since resumed all of his previous duties, Reliance reiterated its earlier conclusion that Dr. Lasser was not "disabled" under the terms of his policy, and affirmed the termination of benefits. *See id.* at 6a-7a.

2. Dr. Lasser then brought suit in federal court, challenging Reliance's denial of benefits under the private-action provision of ERISA, 29 U.S.C. § 1132(a)(1)(B). Both parties moved for summary judgment. The district court (Wolin, J.) denied both parties' motions. *See* App. 78a-104a. The court began by noting that, under this Court's decision in *Firestone Tire &*

Rubber Co. v. Bruch, 489 U.S. 101 (1989), when an ERISA-covered plan expressly gave the administrator discretionary authority to make eligibility decisions, the administrator's decision could be reversed only if it was arbitrary and capricious. *See id.* at 82a-83a. The court read *Firestone*, however, to suggest that "deference might * * * not be appropriate" when the administrator or fiduciary had a conflict of interest (such as when "an insurance company both administrates plan benefits and pays those benefits from its own funds"). *Id.* at 83a. Although the court indicated its desire "not to permit the question of * * * the appropriate standard of review to blur its assessment of the ultimate merits of the case," *id.* at 84a, it ultimately elected to apply "a substantially more stringent level of arbitrary and capricious review" based on (1) the existence of conflicting medical evidence in the administrative record and (2) alleged methodological flaws in a survey used by Reliance to determine Dr. Lasser's previous occupational duties, *id.* at 84a-95a. The court concluded that "it would be inappropriate to grant more than a minimal amount of deference to the [insurer's] resolution of the contested issues before it," *id.* at 94a, though it reserved the right to reconsider the appropriate level of deference at any subsequent trial on the merits, *see id.* at 94a-95a.

Based on its tentative conclusion that a heightened standard of review was applicable, the court denied the motions for summary judgment, on the ground that it could "[a]ssuredly" find for either party under the "heightened" arbitrary and capricious standard. *See id.* at 96a. The court added that, when an administrator or fiduciary had a conflict of interest, summary judgment would be appropriate "only in the rare exception" of cases. *Id.* at 94a n.3.

3. The district court then conducted a bench trial, at which Reliance's claims reviewer was the only witness. *See id.* at 37a. Reversing Reliance's denial of benefits, the district court decided in Dr. Lasser's favor. *See id.* at 35a-77a. The court

cited the conflicting testimony of doctors obtained by Reliance in the course of the administrative appeal, which, in the court's view, indicated (1) that "Dr. Burke [Reliance's independent examining physician] failed to appreciate the risk to Dr. Lasser posed by occupational stress," and (2) that "key points were missing from Dr. Burke's analysis." *Id.* at 44a.

The district court then rejected the insurer's reliance on evidence that Dr. Lasser had resumed all of his previous duties. *See id.* at 53a-55a. The court reasoned that Dr. Lasser's return to work did not "necessarily" negate a finding of disability, but added that, "where the claimant hazards his well-being by returning to work against his doctors' recommendations, return to work should not affect the benefits determination." *Id.* at 53a. The court added that "[t]his is particularly true where a claimant is forced to work by economic considerations." *Id.* at 54a. The court also concluded that Reliance erred by defining Dr. Lasser's previous occupational duties too narrowly. *See id.* at 57a-74a.

On the standard of review, the district court did conclude that there was "no evidence of overt bias exhibited by * * * the claims administrator." *Id.* at 41a. The court thus determined, in an apparent modification of its earlier position, that the appropriate standard was "at the mild end of the heightened arbitrary and capricious scale." *Id.* at 42a. Nevertheless, at the end of its lengthy analysis of the evidence, the court reasoned that the establishment of an appropriate standard of review was apparently an "academic exercise," since the court would have reversed Reliance's determination even under the full-fledged arbitrary and capricious standard. *Id.* at 74a.

4. A divided panel of the Third Circuit affirmed. *See id.* at 5a-21a. Writing for the majority, Judge Ambro acknowledged at the outset that the standard-of-review issue "is more involved in this case than in most." *Id.* at 8a. The court reasoned that, when "the same entity that determines whether a claimant is disabled must also pay for disability benefits," a "structural" or

"inherent" conflict of interest exists because such an entity "has a financial incentive" to conclude that a claimant is not disabled. *Id.* Citing an earlier Third Circuit decision, the court reasoned that "heightened" arbitrary and capricious review was appropriate in such cases, though it reiterated the district court's ultimate conclusion that the correct standard of review in this case was "at the mild end of the heightened arbitrary and capricious scale." *Id.* at 8a-9a.

After addressing the appropriate definition of Dr. Lasser's "regular occupation," and his duties under that occupation, *see id.* at 9a-15a, the court turned to the merits of Dr. Lasser's claim, *see id.* at 15a-19a. The court conceded that Reliance's independent examining physician, Dr. Burke, had concluded that Dr. Lasser had no cardiovascular disability, and that Dr. Burke and other doctors (including Dr. Lasser's treating physician) had concluded, based on their assessments under the New York Heart Association classificatory scheme, that there were not "significant limitations on Dr. Lasser's ability to work as an orthopedic surgeon." *Id.* at 16a. Nevertheless, the court credited the testimony of other physicians over Dr. Burke's. *See id.* at 16a-19a. Notably, the court placed particular weight on the testimony of Reliance's two other reviewing physicians, even though one suffered from a conflict of interest because he had practiced in the same group as a physician retained by Dr. Lasser, and even though the other noted that, while stress could trigger heart attacks, "[t]here is little definitive evidence that emotional or job stress is causally related to the development or acceleration of coronary artery disease." *Id.* at 17a. Based on the testimony of these physicians and Dr. Lasser's own physicians, the court concluded that Reliance's determination that Dr. Lasser was disabled was arbitrary and capricious. *See id.* at 19a.

Finally, the court considered the relevance of Dr. Lasser's resumption of on-call and emergency surgery duties. *See id.* at 20a-21a. At the outset, the court noted that the parties

disagreed on the degree to which Dr. Lasser had resumed those duties. *See id.* at 20a. Even assuming that Dr. Lasser had resumed those duties fully, however, the court noted that there was "substantial medical evidence" that Dr. Lasser was doing so to his detriment. *Id.* Further, the court reasoned that Dr. Lasser's return to work was motivated by economic necessity. *See id.* Citing cases from the Seventh and Eleventh Circuits, the court contended that "[a] claimant's return to work is not dispositive of his or her disability when economic necessity compels him or her to return to work." *Id.* The court reasoned that this principle was "especially persuasive" in this case because Dr. Lasser's disability was latent and did not make it physically impossible for him to perform his job "for a limited period." *Id.* at 21a.

Judge Garth dissented. *See id.* at 21a-34a. He listed six grounds for his dissent, two of which are relevant here. First, Judge Garth reasoned that the district court "failed to adhere to our established standards of review and our precedents." *Id.* at 21a. He contended that the district court "erred by giving only lip service, but no required true deference, to [Reliance's] determinations." *Id.* at 22a.

Second, Judge Garth reasoned that the insurer properly relied on evidence that Dr. Lasser had returned to "full-time" unrestricted work, including on-call and emergency surgery duties. *See id.* at 29a. Judge Garth reasoned that Dr. Lasser could be "totally disabled" only if he satisfied the policy's condition of "inability to perform tasks material to his occupation." *Id.* Citing an Eighth Circuit decision on the issue, Judge Garth reasoned that Dr. Lasser could not claim to be totally disabled when he had returned to work, even if he returned to work out of "economic necessity" and claimed that the stress from his job could aggravate his heart condition. *See id.* at 30a.

In conclusion, Judge Garth contended that the majority's decision would "signal to district courts in the future that they

are free, in similar cases, * * * to deviate from" the arbitrary-and-capricious standard for reviewing decisions by ERISA administrators or fiduciaries. *Id.* at 33a. He reiterated that "a court must *actually apply* the correct standard; *mere lipservice and mere citation* to a standard of review will not suffice." *Id.* at 33a-34a.

5. The Third Circuit denied rehearing by the panel and rehearing *en banc*. *See id.* at 1a-4a. Judge Garth dissented from the denial of panel rehearing. *See id.* at 2a-4a.[1] Judge Garth contended that both the district court and the panel majority "had conducted *de novo* * * * review" and "gave no deference whatsoever to the policy Administrator." *Id.* at 3a. Judge Garth reasoned that rehearing was warranted to "'set the record straight' as to the permissible function of the District Court when it evaluates an Administrator's reasoning," and to "insist[] that the District Court give the required deference to the Administrator." *Id.* This petition follows.

REASONS FOR GRANTING THE PETITION

A. THE THIRD CIRCUIT, IN CONFLICT WITH DECISIONS OF THIS COURT AND OTHER CIRCUITS, ERRED BY APPLYING AN INSUFFICIENTLY DEFERENTIAL STANDARD OF REVIEW TO THE INSURER'S ELIGIBILITY DETERMINATION.

Although the Third Circuit, like the district court before it, purported to review Reliance's determination that Dr. Lasser was not disabled under a "mild" form of "heightened arbitrary and capricious" review, it effectively applied *de novo* review instead. The Third Circuit's approach is inconsistent with that of this Court in *Firestone*, and also with that of other circuits.

1. In *Firestone*, a group of individuals sued their former

[1] As a senior judge, Judge Garth did not participate in the vote on rehearing *en banc*. *See* 28 U.S.C. § 46(c).

employer under ERISA's private-suit provision, claiming, *inter alia*, that they were entitled to severance benefits under an ERISA-covered termination-pay plan. *See* 489 U.S. at 106. The Third Circuit (per Becker, J.) had held that a benefit determination by an ERISA plan administrator should ordinarily be subject to arbitrary and capricious review, but should be subject to *de novo* review when the employer was itself the plan administrator. *See id.* at 107.

This Court affirmed in part and reversed in part. *See id.* at 118. Writing for the Court, Justice O'Connor stated that the determination of the appropriate standard of review in private actions challenging plan administrator decisions should be "guided by principles of trust law." *Id.* at 111. Under those principles, the Court continued, a deferential standard of review was appropriate only when a trustee was exercising discretionary powers. *See id.* The Court concluded, therefore, that a plan administrator's decision was subject to *de novo* review "unless the benefit plan gives the administrator * * * discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. Critically for present purposes, the Court proceeded to note that, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

Since *Firestone*, this Court has provided no further guidance on the degree of deference owed to a plan administrator or fiduciary's eligibility determination when the plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility, but the administrator or fiduciary is operating under a conflict of interest.[2] Most recently, in *Rush*

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[2] In this case, the lower courts repeatedly referred to Reliance as the "plan administrator." Technically, however, Reliance was a "fiduciary," not "administrator," under ERISA. *See* 29 U.S.C. § 1002(16)(A), (21)(A).

Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002), the Court was presented with, but opted not to resolve, the issue of "the degree to which a plan provision for unfettered discretion in benefit determinations guarantees truly deferential review," *id.* at 384 n.15. In a footnote, the Court observed that, in the critical sentence of *Firestone*, it "[had] noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised." *Id.* However, the Court stated only that "[i]t is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest." *Id.*[3]

2. In the wake of this Court's cryptic dictum in *Firestone*, the courts of appeals have struggled to establish standards for the degree of deference owed to discretionary eligibility determinations by a conflicted administrator or fiduciary. *See, e.g., Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000) (Becker, then-C.J.) ("This question, and variations thereof, have bedeviled the federal courts since considered dicta in [*Firestone*] gave opaque direction about how courts should review discretionary benefits denials by potentially conflicted ERISA fiduciaries."); *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (Boudin, J.) ("What constitutes a conflict and how the factor is to be weighed were not explained [in *Firestone*], and naturally the cases in the lower courts are now somewhat divided."). While defying easy classifications, the court of appeals' decisions broadly fall into three main categories.

a. Some circuits have held that the mere existence of a

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[3] Last Term, in *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003), this Court held that ERISA does not require plan administrators or fiduciaries to accord special deference to the opinions of treating physicians. However, the issue of the degree of deference owed to discretionary eligibility determinations by a conflicted plan administrator or fiduciary was not before the Court. *See, e.g.*, Br. of United States in No. 02-469, *Black & Decker Disability Plan v. Nord*, at 27-28 (Feb. 24, 2003).

conflict of interest is insufficient to justify applying a lower standard of review. The Ninth Circuit has held that the deferential "arbitrary and capricious" or "abuse of discretion" standard applies unless the claimant comes forward with "material, probative evidence, *beyond the mere fact of the apparent conflict*, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995) (emphasis added). Such "material, probative evidence" can include "inconsistencies in the plan administrator's reasons, insufficiency of those reasons, or procedural irregularities in the processing of the beneficiaries [*sic*] claims." *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 829 (9th Cir. 2002) (citations omitted), *rev'd on other grounds*, 123 S. Ct. 1965 (2003); *see also Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 798 (9th Cir. 1997) (noting that the claimant must show that "the conflict may have influenced the decision"). Where such evidence exists, the Ninth Circuit employs a rebuttable presumption, with the administrator or fiduciary required to come forward with contrary evidence that the conflict did not affect its decision to avoid being subject to *de novo* review. *See, e.g., Alford v. DCH Found. Group Long-Term Disability Plan*, 311 F.3d 955, 957 (9th Cir. 2002).[4]

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[4] Both the majority and the dissent in this case construed the Ninth Circuit's decision in *Kearney v. Standard Insurance Co.*, 175 F.3d 1084 (9th Cir. 1999) (*en banc*), as mandating *de novo* review in these circumstances, *see* App. 9a n.3 (majority opinion); *id.* at 24a n.3 (Garth, J., dissenting). In *Kearney*, however, the Ninth Circuit merely concluded that the plan at issue did not confer discretion on the administrator to make eligibility determinations, and, consistent with this Court's decision in *Firestone*, thus applied *de novo* review. *See* 175 F.3d at 1090. Indeed, the *en banc* court in *Kearney* expressly did not reach the issue addressed by prior Ninth Circuit panels in *Atwood* and *Lang*: namely, whether the decision of a plan administrator or fiduciary with discretion should be reviewed less deferentially in cases in which the administrator or fiduciary had a conflict of interest. *See id.* at 1090 n.2.

Similarly, while the Sixth Circuit has stated that the existence of a conflict of interest shapes application of the arbitrary and capricious standard of review, *see, e.g.*, *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 984 (6th Cir. 1991), it has noted, in a recent reported but unpublished opinion elaborating on this standard, that "mere allegations of the existence of a structural conflict of interest are not enough; there must be some evidence that the alleged conflict of interest *affected* the plan administrator's decision to deny benefits," *Cochran v. Trans-General Life Ins. Co.*, 12 Fed. Appx. 277, 281 (6th Cir. 2001) (emphasis added) (citing *Peruzzi v. Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998)).

Other circuits have adopted similar tests. The Seventh Circuit requires a claimant to provide "specific evidence of actual bias that there is a significant conflict" before applying a heightened (that is, less deferential) version of the arbitrary and capricious standard. *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998). The Second Circuit, like the Sixth Circuit, has required a claimant to produce evidence that "the administrator was *in fact* influenced by" the alleged conflict of interest. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (emphasis added). And the First Circuit has seemingly rejected any effort to adopt a heightened standard in cases involving a conflict of interest, reasoning that "fine gradations in phrasing are as likely to complicate as to refine the standard." *Doe*, 167 F.3d at 57.

b. A second group of circuits has held that, where a plan administrator or fiduciary is operating under a conflict of interest, the eligibility determinations of the administrator or fiduciary are subject to substantially less deferential review as a matter of course. The Eleventh Circuit has stated that a claimant "need only show that the fiduciary allowed himself to be placed in a position where his personal interest *might* conflict with the interest of the beneficiary." *Brown v. Blue*

Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556, 1565 (11th Cir. 1990) (internal quotation omitted). In cases involving conflicts of interest, the Eleventh Circuit applies a "significantly diminished" degree of deference. *Id.* at 1568. Indeed, to obtain any degree of deference, a plan administrator or fiduciary *itself* bears the burden of "dispelling the notion that its conflict of interest has tainted its judgment." *Id.* Likewise, the Eighth Circuit, citing the Eleventh Circuit's decision in *Brown*, has apparently applied a heightened degree of scrutiny across the board. *See Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997).

c. Finally, still other circuits, including the Third Circuit, have taken an intermediate approach and employed a "sliding scale" of deference. The Fifth Circuit has stated that, under this approach, "[t]he greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be." *Vega v. National Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*). Similarly, the Fourth Circuit has stated that, in the face of a conflict of interest, the deference shown to the decision of a plan administrator or fiduciary "will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict." *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993). The Third Circuit—in a decision cited by the decision below—has adopted the "sliding scale" approach, though it conceded that "there is something intellectually unsatisfying, or at least discomforting, in describing our review as a 'heightened arbitrary and capricious' standard." *Pinto*, 214 F.3d at 392. Finally, the Tenth Circuit has not only adopted the "sliding scale" approach, *see Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826 (10th Cir. 1996), but has also devised a burden-shifting mechanism, under which a conflicted administrator or fiduciary must demonstrate that its decision was *not* arbitrary and capricious, *see Fought v. UNUM Life Ins. Co.*, 2004 WL 228946, at *6-*7 (10th Cir. Feb. 6, 2004) (*per*

curiam).

3. In this case, the lower courts purported to review the insurer's decision to deny benefits under a "mild" form of "heightened" arbitrary and capricious review. *See* App. 9a (Third Circuit); *id.* at 42a (district court). The choice of the appropriate standard of review, however, is seemingly outcome-dispositive in this case. As a threshold matter, *any* "heightened" form of arbitrary and capricious review would be inappropriate under the law of the first group of circuits discussed above. In this case, the district court expressly found, and the Third Circuit did not disagree, that there was "no evidence of overt bias exhibited by * * * the claims administrator." *Id.* at 41a. Because Dr. Lasser came forward only with evidence that a "structural" conflict of interest *existed* (because the insurer had a financial incentive to deny benefits), and did not proffer any evidence that such a conflict actually *affected* the insurer's decision, the lower courts' decision to apply a "heightened" form of arbitrary and capricious review was improper under the law of those circuits.

This case presents a particularly serviceable vehicle for consideration of the appropriate standard of review in cases involving discretionary eligibility determinations by a conflicted plan administrator or fiduciary. The courts below, despite paying "lip service" to a somewhat deferential standard of review, *id.* at 22a (Garth, J., dissenting), effectively afforded the insurer's decision no deference at all. After articulating its supposedly deferential standard of review, the Third Circuit reweighed the evidence before Reliance on whether Dr. Lasser was disabled under the terms of Reliance's policy, *see id.* at 15a-19a, and even shifted the burden of proof from Dr. Lasser to Reliance, *see id.* at 19a-20a. In effect, the court credited the opinions of two of Reliance's physicians (themselves questionable) over that of a third—despite the basic principle that "the existence of contrary evidence does not necessarily render [a] decision arbitrary." *Boardman v. Prudential Ins. Co.*,

337 F.3d 9, 15 (1st Cir. 2003); *see also Milone v. Exclusive Healthcare, Inc.*, 244 F.3d 615, 618 (8th Cir. 2001) (noting that the appropriate inquiry under deferential review is whether a decision is "extraordinarily imprudent or extremely unreasonable," or whether the decision was supported by "more than a scintilla of evidence") (internal quotations omitted). As Judge Garth emphasized, the administrative record in this case was "replete with evidence" supporting Reliance's decision. App. 30a. In short, even under the "sliding scale" standard of review, the Third Circuit got it wrong.

4. Certiorari is warranted on this question because it is a recurring issue of considerable significance, as the flood of court of appeals decisions in the aftermath of this Court's decision in *Firestone* amply demonstrates. ERISA plan administrators and fiduciaries make eligibility determinations in a wide range of different contexts—from decisions on whether claimants are "disabled" under long-term disability-insurance policies, as in this case, to decisions on whether beneficiaries suffered "accidental" injuries for purposes of life-insurance policies, *see, e.g.*, *Mers*, 144 F.3d at 1018, to decisions on whether medical conditions or procedures are covered by health-insurance policies, *see, e.g.*, *Chambers*, 100 F.3d at 820-21. Indeed, as *Firestone* itself illustrates, questions regarding the appropriate standard of review can arise even outside the insurance context. *See* 489 U.S. at 106 (termination-pay plan). If allowed to stand, the Third Circuit's decision threatens to transform federal challenges to discretionary ERISA eligibility determinations in all of these disparate circumstances into "battles of the experts," with reviewing courts increasingly substituting their own judgments for those of better-situated plan administrators and fiduciaries. In light of the disarray in the lower courts and the importance of this recurring issue, this Court's review is warranted.

B. THE THIRD CIRCUIT, IN CONFLICT WITH DECISIONS OF OTHER CIRCUITS, ERRED BY REJECTING THE INSURER'S RELIANCE ON EVIDENCE THAT THE CLAIMANT HAD RETURNED TO WORK.

Not only did it apply an insufficiently deferential standard of review to the insurer's determination that the claimant was not disabled, the Third Circuit effectively placed an additional thumb on the scale by refusing to allow Reliance to rely on evidence that Dr. Lasser had fully returned to work in making that determination. The court of appeals' holding on that issue deepens existing tension among the circuits on whether evidence that a claimant has returned to work may be taken into account in making disability determinations.

1. Contrary to the Third Circuit's approach, two courts of appeals have held that a claimant's return to work constitutes probative, and indeed dispositive, evidence that the claimant is not disabled. In *Galman v. Prudential Insurance Co.*, 254 F.3d 768 (8th Cir. 2001)—the decision on which Judge Garth expressly relied in dissent, *see* App. 30a—the Eighth Circuit considered a long-term disability policy that defined "total disability" as "not working at any job," *Galman*, 254 F.3d at 771. The claimant contended that he had returned to work for financial reasons, and that it would be against public policy to deprive him of benefits simply because he returned to work. *See id.* The Eighth Circuit, however, rejected claimant's contentions. The court noted that the relevant plan language was "plain and unambiguous," and that "unambiguous provisions in ERISA plans must be enforced in accordance with their terms." *Id.* The court added that "[p]ublic policy does not prevent employers from declining to grant total disability benefits to employees who are willing and able to risk returning to work." *Id.* at 772.

Nor is the Eighth Circuit alone. In *Deegan v. Continental Casualty Co.*, 167 F.3d 502 (9th Cir. 1999), the Ninth Circuit

considered a policy virtually identical to the one at issue, under which a claimant was disabled if he or she was "continuously unable to perform the substantial and material duties of his regular occupation," *id.* at 507. The insurer in *Deegan* contended that the claimant was not entitled to benefits as of the date he returned to full-time work. *See id.* Without elaboration, the Ninth Circuit agreed, holding that the claimant was "no longer disabled" as of the date he returned to work and therefore "was not entitled to disability benefits as of that date." *Id.*

2. On the other hand, in decisions cited by the Third Circuit majority, *see* App. 20a-21a, two other circuits have embraced the opposite approach. In those circuits, a claimant's return to work does not constitute even probative evidence that the claimant is not disabled. Most notably, in *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003) (Posner, J.), the Seventh Circuit rejected outright the use of evidence that a claimant has returned to work as evidence of disability.[5] The court characterized the insurer's reliance on evidence that the claimant had returned to work as a "bad argument." *Id.* at 918. It noted that the insurer's argument "would be correct were there a logical incompatibility between working full time and being disabled from working full time, but there is not." *Id.* Citing a series of Seventh Circuit cases involving the definition of "disability" under the Social Security Act (and one case *allowing* the use of evidence of a return to work in the ERISA context), the court reasoned that "[a] desperate person might force himself to work despite an illness that everyone agreed was totally disabling." *Id.* The court added that "even a desperate person might not be able to maintain the necessary level of effort indefinitely," and that "[a]

[5] The policy at issue in *Hawkins*, like the policy here, defined "disability" as an "inability to perform all of the material and substantial duties of [the claimant's] occupation." *See Hawkins v. First Union Corp. Long-Term Disability Plan*, 2002 WL 1592772, at *2 (N.D. Ill. July 19, 2002).

disabled person should not be punished for heroic efforts to work by being held to have forfeited his entitlement to disability benefits should he stop working." *Id.*

In like manner, the Eleventh Circuit, albeit in dictum, has expressed "doubt" as to whether a claimant's status as a full-time employee "constituted evidence that [the claimant] was able to perform the material duties of his occupation on a full-time basis." *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 n.6 (11th Cir. 2001). The court did not definitively resolve the issue because there was evidence that the claimant had not successfully resumed all of his duties on a full-time basis. *See id.*; *cf. Maracek v. BellSouth Telecomms., Inc.*, 49 F.3d 702, 706 (11th Cir. 1995) (holding that temporary return to work, for two days, was insufficient to constitute evidence that claimant was not disabled).

3. In the case at hand, the Third Circuit stated that "[a] claimant's return to work is not dispositive of his or her disability when economic necessity compels him or her to return to work." App. 20a. Yet the Third Circuit refused to acknowledge that a claimant's return to work constitutes even *probative* evidence that the claimant is not disabled.[6] The Third Circuit thereby effectively held that, *as a matter of law*, an insurer may not consider evidence of a claimant's return to work in making an eligibility determination.

That holding is incorrect. The plain language of disability policies such as Reliance's indicates that the relevant inquiry is merely whether a claimant *can* return to work (though nothing precludes an insurer, in its discretion, from taking additional considerations into account). Here, Dr. Lasser demonstrated

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[6] In denying Dr. Lasser's administrative appeal, Reliance cited Dr. Lasser's return to work only as *additional* evidence that he was not disabled. *See* C.A. App. 182-83. But the district court stated, in no uncertain terms, that evidence that Dr. Lasser returned to work "should not [have] affect[ed] the benefits determination." App. 53a.

that he was "capable of performing [all] the material duties of [his] regular occupation" on a full-time basis, *id.* at 42a, by actually performing them. Although it is true that a claimant may be classified as "disabled" for purposes of the Social Security Act even if the claimant returns to work (if, for example, the claimant suffers from a listed impairment, *see, e.g.*, *Barnhart v. Thomas*, 124 S. Ct. 376, 379 (2003)), this Court has declined to "import[]" rules from the Social Security context into the ERISA context because of the "critical differences between the Social Security disability program and ERISA benefit plans," *Black & Decker*, 123 S. Ct. at 1971-72.

4. Certiorari is warranted on this question because it too is a recurring issue of considerable significance. There have now been five court of appeals decisions in the last three years alone on the use of evidence that a claimant has returned to work in eligibility determinations under long-term disability-insurance policies. In every one of those cases, the policies at issue define "disability" in materially identical terms. The basic premise of long-term disability insurance is that it is designed to allow claimants to recover benefits as a replacement (and only a partial replacement at that) for their regular income. If allowed to stand, the Third Circuit's decision, and others like it, will allow claimants to recover benefits as a *supplement* to their income, subject only to the existence of any plan provisions allowing insurers to obtain an offset against such income. The Third Circuit's decision will thereby have the effect of broadening the pool of individuals who can qualify as "disabled," increasing the liabilities of insurers and inexorably driving up premiums. Because the Third Circuit's decision has significant implications for the providers of long-term disability insurance and the millions of individuals they insure, certiorari is warranted on this issue as well.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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FEBRUARY 2004

APPENDIX

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 02-4123

STEPHEN P. LASSER

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Appellant

October 22, 2003

SUR PETITION FOR PANEL REHEARING
WITH SUGGESTION FOR REHEARING *EN BANC*

Present: **SCIRICA,** Chief Judge, **SLOVITER, NYGAARD, ALITO, ROTH, McKEE, RENDELL, BARRY, AMBRO, FUENTES, SMITH** and **GARTH,*** Circuit Judges.

The petition for rehearing filed by Appellant having been submitted to the judges who participated in the decision of this Court, and to all the other available circuit judges in active service, and only Judge Garth who has voted for panel rehearing, and no other judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges

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* Senior Judge Garth, who sat on the original panel, is limited to panel rehearing only.

of the Circuit in regular active service not having voted for rehearing by the court *en banc*, the petition for rehearing is **DENIED**.

By the Court

/s/
Thomas L. Ambro, Circuit Judge

OPINION SUR DENIAL OF PETITION FOR REHEARING

GARTH, Circuit Judge.

As a Senior Judge, I can only vote for panel rehearing and not for full court rehearing. Despite this limitation, and even with the realization that my vote may be futile in light of the majority opinion that has been filed in this case, I nevertheless vote for panel rehearing.

I do so because I have a very substantial concern, as expressed in my panel dissent, that District Court judges following the majority opinion may not be inclined to apply the Ninth Circuit standard of review as expressed in *Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999) (*en banc*). The *Kearney* standard in the instant case was adopted and applied by the District Court, even though it is a radical and significant departure from the standard which this Circuit has prescribed. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 387, 392 (3d Cir. 2000). This Court has always employed a standard which requires deference to the Administrator of a Plan, and we have never, as *Kearney* holds, permitted *de novo* review. See *Kearney*, 175 F.3d at 1090 fn.2 ("[W]e conclude that *Kearney* is entitled to de novo review, which gives no deference at all to Standard's decision.").

Despite this telling difference and departure from our fundamental jurisprudence of how we review a Plan Administrator's decision, the majority opinion has condoned what I, in my dissent, have condemned. My panel dissent charged that the District Court and the majority had conducted *de novo* fact finding and review — and this, despite the majority's concession agreeing with me that *Kearney* is *not* the law of the Third Circuit. I took that position because throughout their respective opinions, both the District Court and the majority in reviewing the District Court gave no deference whatsoever to the policy Administrator. I therefore repeat what I had stated in my panel dissent and what the Supreme Court has mandated: A Court must *actually apply* the current standard; *mere lip service and mere citation* to a standard of review will not suffice. *See Price v. Vincent,* 123 S. Ct. 1848, 1852 (2003) (holding that the Sixth Circuit recited the correct standard of review, 28 U.S.C. § 2254(d), but did not apply it when reviewing the double jeopardy question at issue).

I believe this Court should have granted rather than denied rehearing so that it could have "set the record straight" as to the permissible function of the District Court when it evaluates an Administrator's reasoning, analyses and conclusion, and it should have insisted that the District Court give the required deference to the Administrator.

There are other issues presented in the petition for rehearing, including the appropriate burden of proof when an insurance plan's conclusion is at odds with the treating physician's opinion in an ERISA case under *Black & Decker Disability Plan v. Nord,* 123 S. Ct. 1965 (2003), and the appropriate evidentiary weight to be accorded to the DOT and the labor market survey, *see, e.g., Russell v. Paul Revere Life Ins. Co.*, 288 F.3d 78, 82 (3d Cir. 2002). I believe these are meritorious issues if applied appropriately, and should have resulted in a holding sustaining the Administrator's conclusion rather than rejecting it. I do not discuss those issues here in detail because I

believe that the fundamental problem with the majority's opinion is its tolerance and acceptance of an erroneous standard of review and its proscribed application by the District Court.

This being said, and for all of the other reasons set forth in my panel dissent, I can only hope that this case does not lead other judges in this Circuit astray when confronted with policy terms and Administrator's decisions similar to those presented in *Lasser*.

I therefore respectfully vote for panel rehearing.

APPENDIX B

THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 02-4123

STEPHEN P. LASSER

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Appellant

September 18, 2003

Before **SCIRICA,** Chief Judge, **AMBRO** and **GARTH**, Circuit Judges.

AMBRO, Circuit Judge.

Reliance Standard Life Insurance Company argues that the District Court incorrectly held arbitrary and capricious its determination that Stephen Lasser was not disabled within the terms of his disability insurance policy. We conclude that the Court did not err and therefore affirm.

I. Background

Dr. Stephen Lasser is an orthopedic surgeon who was employed by Townsquare Orthopedic Associates ("Townsquare"), a four-doctor practice group. He sued to obtain disability benefits he alleges Reliance Standard Life Insurance Company ("Reliance") owes him under the disability

insurance policy Townsquare purchased from Reliance (the "Policy"). The Policy pays disability benefits when, because of injury, illness or disease, a claimant "is capable of performing the material duties of his/her regular occupation on [only] a part-time basis or [only] some of the material duties on a full-time basis."

Dr. Lasser suffers from coronary artery disease. In 1986, at age 46, he underwent coronary bypass surgery. As later became apparent, the surgery was not correctly performed.[1] Although Dr. Lasser did not experience symptoms for the next decade following the 1986 surgery, in 1996 he suffered a myocardial infarction (colloquially, a "heart attack"). Dr. Robert Aldrich, Lasser's treating physician, prescribed a treatment regimen of change of diet, exercise, and drug therapy. Dr. Aldrich also advised Lasser to reduce his stress level, including work-related stress. Accordingly, in September 1996 Dr. Lasser returned to work on a reduced schedule. He decreased his patient load by 50%, he was no longer "on-call" at night or on weekends, and he did not perform emergency surgery. On December 26, 1996, Reliance approved Dr. Lasser's application for long-term disability benefits under the Policy.

However, in December 1997, after a periodic review of Dr. Lasser's condition — and primarily in response to a medical evaluation issued by Dr. William Burke, whom Reliance hired to evaluate Dr. Lasser — Reliance terminated Lasser's benefits on the ground that he was not disabled as defined by the Policy. Dr. Lasser invoked Reliance's administrative appeal procedures, which prompted Reliance to obtain two additional

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[1] Rather than performing an artery graft, Lasser's surgeon conducted a vein graft procedure. Whereas artery grafts have a relatively high success rate, vein grafts have a significant failure rate — according to Lasser's physicians, between 50% and 60% after ten to fifteen years. Moreover, Lasser's vein graft, rather than being connected to another artery (as it should have been), was sewn to two diagonal branches, only one of which was supplying blood to the anterior descending artery.

medical opinions — from Drs. Karel Raska and John Field — as well as to commission a labor market survey to determine the material duties of Dr. Lasser's general occupation. Based on these medical opinions and the survey — as well as the fact that Dr. Lasser returned to work at a full-time schedule (including on-call and emergency surgery duties) — in April 1999 Reliance concluded that Dr. Lasser was not disabled from performing the material duties of his occupation and affirmed its earlier denial of benefits.

Dr. Lasser then filed a complaint in the District Court. In a February 8, 2001 opinion, it denied both parties' cross-motions for summary judgment and stated that it would hold a hearing to determine the proper standard of review.[2] *Lasser v. Reliance Standard Life Ins. Co.*, 130 F. Supp. 2d 616, 630 (D.N.J. 2001). After holding that hearing and deciding that a moderately heightened arbitrary and capricious standard of review was appropriate, the Court reviewed the record before Reliance. On the basis of its review, it held Reliance's determination of nondisability arbitrary and capricious and that Dr. Lasser was entitled to benefits. Reliance appeals.

II. Jurisdiction

The insurance policy at issue is covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* Dr. Lasser sued to recover benefits under the Policy, and ERISA preempts state-law claims in this context.

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[2] The Court's stated basis for denying summary judgment was that "a court could find for either party when considering the administrator's resolution of these factual questions under the heightened standard of arbitrary and capricious review," and that "the parties have advanced to the Court some factual support for each of their positions on the underlying merits of the claim as well as on the extent to which the administrator's decision was tainted by his self interest." *Id.* at 626-27. Our dissenting colleague suggests that the District Court erred by considering extra-record evidence in resolving the merits. We disagree. The District Court recognized that its review was limited to the record before the claims administrator. *Id.* at 630.

Id. § 1132(a). Thus, the District Court had jurisdiction pursuant to 28 U.S.C. § 1331. We exercise appellate jurisdiction under 28 U.S.C. § 1291.

III. Standard of Review

The standard-of-review inquiry is more involved in this case than in most. The Supreme Court has mandated that courts review under the arbitrary and capricious standard claim denials in ERISA cases if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989). "Under the arbitrary and capricious standard, an administrator's decision will only be overturned if it is without reason, unsupported by substantial evidence or erroneous as a matter of law [and] the court is not free to substitute its own judgment for that of the defendants in determining eligibility for plan benefits." *Pinto v. Reliance Standard Life Ins. Co.,* 214 F.3d 377, 387 (3d Cir. 2000) (internal quotation marks omitted). Here both parties agree that the Policy grants Reliance such authority.

However, if the same entity that determines whether a claimant is disabled must also pay for disability benefits, that entity has a financial incentive to find him or her not disabled. Thus, we have noted that, when the insurer of an ERISA plan also acts as a claims administrator, there is a structural or inherent conflict of interest that mandates a "heightened" arbitrary and capricious standard of review. *Id.* at 378. In *Pinto* we employed a "sliding scale" approach in which the level of scrutiny applied to the fiduciary's decision is "a range, not a point." *Id.* at 392 (quoting *Wildbur v. ARCO Chem. Co.,* 974 F.2d 631, 638 (5th Cir. 1992)). It is "more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is." *Id.* at 392-93.

The District Court held a hearing on the extent of Reliance's conflict of interest to determine the standard of review.

Because the Court found no evidence of conflict other than the inherent structural conflict, it held that the correct standard of review was "at the mild end of the heightened arbitrary and capricious scale," and thus afforded a "moderate degree of deference" to Reliance's determinations. Neither party disputes this conclusion on appeal. However, Reliance argues that the District Court misapplied the standard by not deferring to Reliance's allegedly reasonable conclusions.[3]

IV. Discussion

A. Dr. Lasser's Regular Occupation

Under the explicit terms of Dr. Lasser's Policy, he is disabled, inter alia, if as a result of injury, illness or disease he is capable only "of performing the material duties of his/her regular occupation on a part-time basis or some of the material duties on a full-time basis." To determine whether Reliance correctly decided that Dr. Lasser did not qualify for disability benefits, we first determine what is his "regular occupation," as the Policy leaves this term undefined. Reliance argues that "regular occupation" is broad, indeed generic. In initially denying Dr. Lasser benefits in December 1997, Reliance said that "regular occupation is not your job with a specific employer, it is not your job in a particular work environment, nor is it your speciality in a particular occupational field. In evaluating your eligibility for benefits, we must evaluate your inability to perform your own or regular occupation as it is

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[3] The dissent criticizes the District Court for making *de novo* findings of fact on the basis of the Ninth Circuit's decision in *Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999), and notes that our Court has never adopted the *Kearney* approach. We agree with the dissent that *Kearney* is not the law in our Circuit and that *de novo* factfinding is improper in reviewing a claims administrator's decision under the arbitrary and capricious standard of review. But we do not believe that the District Court's reference to, and implicit endorsement of, *Kearney* constituted reversible error, for its reference to facts was explicitly "limited to that evidence before the claims administrator." 146 F. Supp. 2d at 621.

performed in a typical work setting for any employer in the general economy."

We recognize that, if the meaning of "regular occupation" is ambiguous, Reliance's definition is entitled to deference under the applicable arbitrary and capricious standard of review. *Skretvedt v. E.I. DuPont de Nemours & Co.*, 268 F.3d 167, 177 (3d Cir. 2001) (insurer's interpretation of an ambiguous insurance provision is entitled to deference unless it is contrary to the plan's plain language). However, we believe that "regular occupation" is not ambiguous. The Policy states that it protects the insured from inability to "perform the material duties of his/her regular occupation." Both the purpose of disability insurance and the modifier "his/her" before "regular occupation" make clear that "regular occupation" is the usual work that the insured is actually performing immediately before the onset of disability. Applying the text as written, Dr. Lasser's regular occupation was as an orthopedic surgeon responsible for emergency surgery and on-call duties in a relatively small practice group and within a reasonable travel distance from his home in New Jersey.

Even assuming "regular occupation" is susceptible to multiple interpretations and therefore ambiguous, Reliance's definition of the term nonetheless must be reasonable before deference is conferred. *See Skretvedt,* 268 F.3d at 177 (noting that courts defer to a claims administrator's interpretation if it is not arbitrary or capricious). Yet Reliance's definition is different from that in the caselaw pertaining both to it and disability policies containing the "regular occupation" modifier. *See O'Bryhim v. Reliance Standard Life Ins. Co.*, 188 F.3d 502 (Table), 1999 WL 617891 (4th Cir. 1999) (unpublished *per curiam*) (on arbitrary and capricious review, holding that claimant could not perform material duties of his regular occupation and defining "regular occupation" with reference to specific duties performed for his employer).

Even were a court not to limit itself exclusively to the claimant's extant duties, that person's "regular occupation" nonetheless requires "some consideration of the nature of the institution [at which the claimant] was employed." *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 253 (2d Cir. 1999). Moreover, *Kinstler* adopted the reasoning of an earlier district court case, *Dawes v. First Unum Life Insurance Co.*, 851 F. Supp. 118, 122 (S.D.N.Y. 1994), which defined "regular occupation" as "a position of the same general character as the insured's previous job, requiring similar skills and training, and involving comparable duties." *Id.* at 122. Notably, *Dawes* was decided before Dr. Lasser applied for disability benefits.

The plain meaning of "regular occupation" is one of which both parties were aware when the Policy began on June 1, 1993. There is no reason to believe that Dr. Lasser was aware of Reliance's different definition until it denied him benefits in December 1997. Because Reliance has shown no intent to "opt out" of this plainly understood term (indeed, it had the opportunity to do so each June when the Policy came up for renewal), it is unreasonable for it to argue it has done so *post hoc*. Even if we fall back to the interpretation of "regular occupation" imparted by *Dawes* and *Kinstler*, it too undermines Reliance's generic understanding. *Compare also Gaines v. The Amalgamated Ins. Fund*, 753 F.2d 288, 290 n.5 (3d Cir. 1985) (deferring to a plan administrator's construction of an ERISA-governed insurance policy when there was no caselaw interpreting the provision at issue); *Epright v. Envtl. Res. Mgt., Inc. Health & Welfare Plan*, 81 F.3d 335, 340 (3d Cir. 1996) (holding a plan construction unreasonable when, among other deficiencies, the administrator pointed to no statutory provision to interpret the term and when its definition seemed self-serving).

In this context, it is unreasonable for Reliance to define "regular occupation" differently from its plain meaning or even

the somewhat more relaxed understanding of *Dawes* and *Kinstler* without explicitly including that different definition in the Policy.[4]

B. Material Duties of Dr. Lasser's Regular Occupation

Having determined that Dr. Lasser's regular occupation under the Policy was that of an orthopedic surgeon in a four-person practice group in New Jersey, and that it was unreasonable for Reliance *post hoc* to argue that the Policy's plain language was otherwise, we turn to what Dr. Lasser did in the course of his regular occupation. He saw patients during office hours, performed scheduled surgeries, took night call, and performed emergency surgeries. When he no longer handled night call and emergency surgeries, were they material? The District Court answered yes. 146 F. Supp. 2d at 641.

The Court's conclusion is supported by comparing Dr. Lasser's pre-disability earnings with his post-disability earnings from a reduced schedule. The Townsquare shareholders' agreement requires reduction by one-third of a doctor's salary when he or she no longer takes night call. Moreover, Dr. Lasser's salary was, on average, approximately $26,000 per month when he was performing all duties, but fell to between $4,000 and $6,000 per month immediately before Reliance terminated benefits. During this latter period, however, Dr. Lasser was working less than forty hours per week, as he reduced his patient load by one-third and no longer was operating in the afternoon after seeing patients in the morning. Even assuming he was working twenty hours per week instead of forty (an assumption supported by record evidence), and assuming that he would have made $8,000 to $12,000 per month had he worked forty hours per week (*i.e.*, double his twenty-hour-per-week earnings), it stands out that, by not performing on-call or emergency surgery duties, Dr. Lasser's

[4] As noted below, the generic ex post interpretation of Reliance is even at odds with the majority of survey responses solicited by Reliance.

earnings have declined by over 50%. This substantial earnings decline lays out as little else can the materiality of those activities to his regular occupation.

Looking at the occupation of an orthopedic surgeon generically without reference to Dr. Lasser's particular duties, Reliance commissioned a labor market survey to determine whether performing emergency surgery and being on- call are material duties for an orthopedic surgeon.[5] The survey asked:

In general, in your experience is it reasonable that an Orthopedic Surgeon can practice in this field if one:

> [1.] Cannot perform "on-call" duties, do night calls, or carry a pager[;]
>
> [2.] Cannot perform emergency surgery (even if one can do non-emergency, elective surgery)[;]
>
> [3.] If you have responded YES to either, can you estimate in your experience the appx. prevalence of such jobs for an orthopedic surgeon in the general

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[5] Reliance also consulted the Dictionary of Occupational Titles ("DOT") to aid its analysis. It points out that the DOT contains no separate listing for an orthopedic surgeon, which appears as an undefined related title under the "surgeon" heading. Therefore, applying the definition of surgeon, which does not refer to on-call and emergency duties, Reliance argues that these duties are immaterial. We agree with the District Court that the DOT's silence about this critical issue makes the DOT unhelpful and thus, to the extent that Reliance's conclusion is based on the DOT's definition of surgeon, that conclusion is unreasonable.

Ironically, in arguing that Dr. Lasser's duties should be evaluated with reference to the surgeon title in the DOT, Reliance acknowledged that surgery — rather than orthopedics — is the broader "occupational field" in which Dr. Lasser conducts his "regular occupation." However, in relying on the survey to find Dr. Lasser not disabled, Reliance must have concluded that his "occupational field" is orthopedics rather than orthopedic surgery — *i.e.*, that his "regular occupation" is one in which it is reasonable to conduct an office practice only or write reports, which some of the survey respondents suggested as available options. Reliance's inconsistency in position renders its ultimate disability decision even more suspect.

economy where one would not need to perform "on-call" or perform emergency surgery duties?

Reliance's vendor sent 100 surveys, to which it received fourteen responses, only nine of which were returned in time to be considered. Five of those nine respondents opined that an orthopedic surgeon could "practice in this field" without performing on-call or emergency surgery duties. On the basis of the survey, and on the absence of any affirmative showing from Dr. Lasser that performing emergency surgery and being on-call are material duties of an orthopedic surgeon generally, Reliance concluded that these duties are immaterial, thereby precluding Dr. Lasser from disability benefits within his Policy's terms.

While Reliance selected survey responses to argue that on-call and emergency surgery duties were not material for Dr. Lasser, we (like the District Court) conclude that Reliance's survey actually favors Dr. Lasser's argument that these duties are material even on a generic basis.[6] When all fourteen responses are considered and when the respondents' comments are viewed along with the answers to the yes/no questions, the survey indicates that performing emergency surgery and being on-call are material duties of an orthopedic surgeon. Eight out of fourteen responses suggest that practice without these duties would be impossible or would result in an occupation fundamentally different from orthopedic surgery. One respondent wrote that the practice Reliance proposed would be very unusual and would essentially be a non-operative practice. Another stated that "[t]he only jobs that I know of that would fulfill your restrictions would be someone who restricted themselves [sic] to writing reports. Work-comp. or med-legal."

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[6] And given that doctors will inevitably have less scheduling flexibility when they work in smaller rather than larger practice groups, it seems only reasonable to conclude that the survey would have been even *more* favorable to Lasser had it taken into account the relevant context of his practice at Townsquare.

A third respondent noted that "[i]n your example, you are describing a physician who is not an orthopaedic surgeon, but might be considered an orthopaedist. An orthopaedic surgeon should be able to fulfill all duties." Five other respondents flat-out said that what Reliance proposed was impossible.

In this context, both Dr. Lasser's particular case and the survey for orthopedic surgeons in general lead to the conclusion that on-call and emergency surgery duties were material to his regular occupation.

C. Ability of Dr. Lasser to Perform the Material Duties of His Regular Occupation

1. Merits

We next determine whether Dr. Lasser's medical condition precludes him from safely performing material duties of his regular occupation. He argues that he cannot safely perform emergency surgery or perform on-call duties. To fulfill our appellate review function under the arbitrary and capricious standard, we examine the entire record to determine whether Reliance's determination is supported by substantial evidence. *Pinto,* 214 F.3d at 387.

Reliance's primary motivation for discontinuing Dr. Lasser's benefits in December 1997 appears have been a report issued by Dr. Burke. He examined Dr. Lasser, subjected him to a treadmill test in November 1997, and concluded that Dr. Lasser "does not demonstrate any cardiovascular disability."[7] During an earlier treadmill test performed by Dr. Steven Roth in April 1997, Dr. Lasser "achieved greater than 90% of age-predicted maximum [heart rate]" and experienced only "mild fatigue [after] 14 minutes." A nuclear cardiologist, Dr. Christos Christou, noted that planar imaging of Dr. Lasser's heart

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[7] Dr. Burke described Lasser's prognosis as "excellent" with a "plaque stabilizing regimen" and "ace inhibitors to prevent the slight hypertensive response associated with exercise."

conducted during the cardiovascular testing revealed only a "very small and probably clinically insignificant" heart defect.

Furthermore, Reliance notes that Dr. Lasser's physician, Dr. Aldrich, considered Lasser to be in New York Heart Association Functional Class II ("Patients with cardiac disease with slight limitation of physical activity. They are comfortable with mild exertion but experience symptoms with the more strenuous grades of ordinary activity.") and Therapeutic Class C ("Patients with cardiac disease whose ordinary physical activity should be moderately restricted and whose more strenuous efforts should be discontinued.") — classifications that do not suggest significant limitations on Dr. Lasser's ability to work as an orthopedic surgeon.[8]

Dr. Lasser, however, contends that Reliance's conclusion is unsupported by substantial evidence. He notes that, after appealing the discontinuation of his benefits, Reliance engaged two other physicians to evaluate him, both of whom issued reports supporting his position. The first, Dr. Raska, concluded that Dr. Lasser "should avoid stressful situations — i.e., those that require night call [and] medical emergencies," and that "[a] reduced stress work environment and schedule is absolutely necessary to maintain this patient's health." Dr. Raska reasoned that "[s]tress regardless of exercise tolerance is a recognized independent risk factor for recurrent coronary artery disease * * * [and that] there are multiple studies * * * which demonstrate that stress causes flux in the level of catecholamines in the circulation which have been shown to be a precipitant of acute myocardial infarction and sudden death." In Dr. Raska's opinion, Lasser's unsuccessful vein graft made

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[8] Reliance also points out that Dr. Burke considered Lasser to be in Functional Class I ("Patients with cardiac disease but with no limitation of physical activity. Ordinary activity causes no undue dyspnea, anginal pain, fatigue or palpitation.") and Therapeutic Class A ("Patients with cardiac disease whose physical activity need not be restricted."). Dr. Raska said that Lasser was in Functional Class I and Therapeutic Class C.

stress reduction especially important, as increased stress could bring about even earlier failure of the graft. In this context, he opined that Dr. Lasser's disability benefits should not have been revoked because he "cannot safely perform the material duties of an orthopedic surgeon."[9]

After receiving this report, however, Reliance realized that Dr. Raska had a conflict of interest: he practiced in the same physician group as a doctor from whom Dr. Lasser previously sought an evaluation, Dr. Lubow (whose evaluation is discussed below). In response, Reliance engaged Dr. Field as another evaluating physician. While Dr. Field noted that "[t]here is little definitive evidence that emotional or job stress is causally related to the development or acceleration of coronary artery disease," he did acknowledge that "both physical and emotional stress are identified triggers of acute myocardial infarction [heart attack]." He concluded that Dr. Lasser could work a forty-hour week, but "is not capable of resuming all of the customary duties and responsibilities of an orthopedic surgeon." In particular, Dr. Field opined that Lasser should restrict his on-call or emergency surgery duties, given their stressful nature.

Dr. Lasser also relies on the evaluation of his treating cardiologist, Dr. Aldrich, as well those of Drs. Barry Lowell and Lawrence Lubow, who all opined that he is disabled. First, Lasser argues that the evaluation issued by Dr. Aldrich suggests that he is incapable of working in his regular occupation. When

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[9] Moreover, Dr. Raska was sharply critical of Dr. Burke's evaluation, the basis of Reliance's initial decision to terminate benefits. While according to Dr. Burke Lasser underwent a treadmill stress test in which he exercised to Stage IV of the Bruce Protocol (the standard by which stress tests are typically conducted), Dr. Raska pointed out that Lasser was only on the treadmill for three minutes and thirty-six seconds, an insufficient duration for a patient to reach Stage IV. He also noted that Dr. Burke's examination of Lasser's records was "sloppy" because it described a heart catheterization occurring in October 1996, when in fact it was performed in July 1996. To Dr. Raska this error suggested that Dr. Burke was insufficiently familiar with Lasser's case to arrive at a reasoned evaluation of his condition.

Reliance asked Dr. Aldrich to complete a form detailing Dr. Lasser's "current restrictions and limitations," he responded that Lasser should "limit exposure to physical and emotional stress." He noted also that "[s]tress is a well-documented risk factor not only for the development of coronary artery disease itself, but within that context, to the precipitation of a myocardial infarction." As a result, in a letter to Reliance dated June 3, 1998, Dr. Aldrich expressed to Reliance that he believed Dr. Lasser is disabled and incapable of "resuming all of the customary duties and responsibilities of an orthopedic surgeon on a full-time basis[,] or at least that he could not do so without exposing himself to a high degree of risk." Dr. Aldrich's reasoning underlying this conclusion was that, even though "by all objective criteria Dr. Lasser is doing very well at this point in time," work-related stress might induce a deterioration in Dr. Lasser's condition. Moreover, according to Dr. Aldrich's reasoning, a favorable classification under the New York Heart Association guidelines is of limited use in Dr. Lasser's situation, as that classification system addresses a cardiac patient's ability to perform certain physical tasks without regard to stress.

Dr. Lowell, who performed a cardiac catheterization on Dr. Lasser, also opined that Lasser was disabled. He agreed with Dr. Burke that Lasser's "functional stress test at the present time is excellent," but cautioned that "the stress of his profession will contribute to poorer control of blood pressure and lipid therapies" and that "a less stressful environment would contribute to his graft longevity." Dr. Lowell concluded that "the severity of Dr. Lasser's heart condition, while not readily measured by traditional testing methods, renders him just as disabled as the patient whose disability would not be questioned because he presents with more overt symptoms."[10]

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[10] He too criticized Dr. Burke's report for its failure to mention the "significant anatomic problems with Dr. Lasser's coronary anatomy."

Finally, Dr. Lubow, a physician who examined Dr. Lasser at the request of Lasser's counsel, reached a conclusion similar to that of Drs. Aldrich, Raska, and Lowell. He opined that, "[b]ased on the recurrence of significant arteriosclerotic heart disease manifest[ed] by an acute infarction plus the need for urgent angioplasty and stenting after a ten year hiatus when he had no symptoms, the decision to grant this patient permanent partial disability was certainly correct, particularly in view of his anatomy."[11]

Thus, all evaluating physicians — with the exception of Dr. Burke, whose report the others discredited — agreed that Dr. Lasser's heart condition precludes him from safely performing on-call duties and emergency surgery. Reliance's conclusion to the contrary thus is arbitrary and capricious. To the extent that Reliance's determination of nondisability was that "it was unreasonable * * * to expect Reliance * * * to simply accept the opinion [that stress would exacerbate Dr. Lasser's condition] without any range of the probability or actual proof that Dr. Lasser was at increased harm," we believe its determination was faulty.

2. Clarification Regarding Burden of Proof

We conclude with a clarification regarding the burden of proof in disability cases. While the burden of proving disability ultimately lies with Dr. Lasser, to require him to provide statistics detailing the harm that working in his regular occupation might precipitate — as the dissent would require — raises the bar too high.[12] Most disability claimants will not

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[11] Like Drs. Aldrich, Raska, and Lowell, he also criticized the thoroughness of Dr. Burke's review, as well as the improper manner in which he conducted Lasser's stress test.

[12] The dissent states that the risk that stress will cause future injury is insufficient to constitute a present disability. However, whether risk of future effects creates a present disability depends on the probability of the future risk's occurrence. While Lasser's doctors have not precisely quantified the risk in his case, their reports suggest that the risk is high.

have the means at their disposal (financial or otherwise) to obtain this kind of evidence. Therefore, once a claimant makes a *prima facie* showing of disability through physicians' reports (as Dr. Lasser has done here through physicians' reports stating that stress will exacerbate his heart condition) and if the insurer wishes to call into question the scientific basis of those reports (as Reliance has attempted to do here), then the burden will lie with the insurer to support the basis of its objection. It has not met that burden here.

D. Relevance of Alleged Resumption of Dr. Lasser's On-Call and Emergency Surgery Duties

Reliance argues that, even if emergency surgery and on-call duties are material, Dr. Lasser's resumption of these duties settles whether he is disabled from performing them. We disagree. First, because Dr. Lasser disputes that he has resumed performing these duties with the same frequency as before 1996, this issue involves a factual question that we do not resolve on appeal. Moreover, even assuming the facts as Reliance has alleged them, Dr. Lasser's physicians — as well as Dr. Field, on whose opinion Reliance has placed much weight — have advised that he should not perform these duties. Thus, there is substantial medical evidence that, if Dr. Lasser is performing on-call and emergency surgery duties, he is doing so to his detriment. Indeed, Dr. Lasser has argued that, to the extent that he has resumed these activities, he did so out of economic necessity — because Reliance discontinued his benefits. A claimant's return to work is not dispositive of his or her disability when economic necessity compels him or her to return to work. *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914, 918 (7th Cir. 2003) ("A desperate person might force himself to work despite an illness

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While of course stress does not *necessarily* incapacitate an individual (note, for example, Vice President Cheney), in Lasser's case his doctors have opined that stress is incapacitating.

that everyone agreed was totally disabling."); *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 n. 6 (11th Cir. 2001) (a claimant's status as a full-time employee should not constitute reliable evidence that he is able to perform the material duties of his occupation on a full-time basis); *Stark v. Weinberger*, 497 F.2d 1092 (7th Cir. 1974) (even if a claimant returns to work, her doing so does not mean she is not disabled). This principle is especially persuasive here, where Dr. Lasser's disability was not observable and did not make it physically impossible for him to perform his job for a limited period.

* * *

We hold that Dr. Lasser's "regular occupation" was that in which he was actually engaged immediately before becoming disabled: an orthopedic surgeon in a four-person practice group in New Jersey. We also hold that on-call and emergency surgery duties are material to Dr. Lasser's practice and that he is disabled from performing those duties. We agree with the District Court that Reliance's conclusion to the contrary was unsupported by substantial evidence and therefore was arbitrary and capricious. We accordingly affirm the District Court's judgment in favor of Dr. Lasser.

GARTH, Circuit Judge, dissenting.

I am obliged to dissent from the majority's judgment in favor of Dr. Lasser.

(1) The District Court failed to adhere to our established standards of review and our precedents. See *Lasser v. Reliance Standard Life Ins. Co.*, 130 F. Supp. 2d 616, 630 (D.N.J. 2001) ("*Lasser I*") ("th[is] Court anticipates adopting the procedure set forth in *Kearney [v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999) (en banc)] and making plenary findings of fact pursuant to Federal Rule of Civil Procedure 52, even though no

new evidence may be received on that branch of the case.")[1] By so doing, the District Court erred by giving only lip service, but no required true deference, to the Administrator Walsh's determinations even after it had held that the Administrator was neither conflicted nor biased. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000).

(2) This is a summary judgment case. The District Court, when called upon to decide summary judgment, cannot hold a trial on the merits a la *Kearney. See infra* note 3. In this case, the District Court did just that.

(3) The District Court, at its truncated April 10, 2001 hearing, while purporting to resolve only the Administrator's status as to whether he was conflicted or biased (it held that he was neither), cannot proceed to ignore our prescribed standard of review which requires deference and then proceed to substitute its own judgment on the merits.

(4) The policy written by Reliance requires that for disability benefits, Dr. Lasser had to be disabled from performing the *material* duties of his regular occupation. The burden of proving materiality rested on Dr. Lasser. No evidence of materiality appears in the record.

(5) No deference was shown by the District Court to Mr. Walsh's, the Administrator's, determinations that: (a) materiality was not demonstrated; (b) Dr. Lasser returned to, and was performing, his full-time occupation; (c) "emergency" and "on-call" services were not established as material; yet, these were the only services Dr. Lasser was told not to perform; and (d) neither stress nor future disabilities could establish Dr. Lasser's *present* disability.

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[1] The District Court filed two opinions in this case. On February 8, 2001, it filed *Lasser I*, 130 F. Supp. 2d 616, and on June 13, 2001, it filed *Lasser v. Reliance Standard Life Ins. Co.*, 146 F. Supp. 2d 619 (D.N.J. 2001) ("*Lasser II*").

(6) The actions taken by Reliance and the evidence relied upon by Reliance, as well as the determinations made by Walsh, the Administrator, cannot be determined to be arbitrary nor capricious under our standards and precedents.

I

This appeal comes to us after both parties had moved for summary judgment. It has remained a summary judgment case in which the District Court could look only to the developed administrative record.

I begin by briefly outlining the pertinent procedural history. In its February 8, 2001 opinion, the District Court denied the parties' cross-motions for summary judgment. It then stated that it would hold a hearing to determine if Walsh, the Administrator, was biased or suffered a conflict because he was an employee of Reliance. *Lasser I,* 130 F. Supp. 2d at 625-26, 630 (referring to *Pinto*'s sliding scale of arbitrary and capricious review).[2]

The District Court then conducted a bench trial on April 10, 2001 where it heard only Walsh's testimony relevant to the issue of how heightened our standard of review should be on *Pinto*'s sliding scale. Dr. Lasser did not testify, nor did any other witness. *I reiterate — the only purpose of the hearing was to address whether Walsh was conflicted or biased because he was Reliance's employee.* Walsh had the duty of determining a claimant's eligibility for benefits as well as of paying those benefits out of the funds from which Reliance reaps its profits. If biased, then under *Pinto* the deference to be accorded his determination would be less deferential, and the court must "calibrat[e] the intensity of [the] review to the intensity of the conflict." *Pinto,* 214 F.3d at 393. If not biased,

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[2] *Pinto* held that, "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." *Pinto*, 214 F.3d at 378.

then under *Pinto,* the standard of deference to be employed would be "deferential, but not absolutely deferential." *Id.* But, in either event, deference had to be accorded.

Thereafter, the District Court determined that it would give a "moderate degree of deference" to Walsh's determinations as it found no evidence of bias or conflict exhibited by Walsh. *Lasser II,* 146 F. Supp. 2d at 623.

At this stage, the District Court was required to end its inquiries and hearing and review the existing administrative record — and no more. But, the District Court did not do that. It proceeded further, despite the summary judgment context of the instant case, and it made its own findings of fact on the merits. *Id.* at 620, 642.

Under our precedents, district courts cannot conduct so-called "merits-trials" when determining the appropriate conflict-of-interest review standard.[3] As I have stated, the District Court should have limited its findings to a determination of what the appropriate standard of review would be, and then should have continued on to resolve the summary judgment question pursuant to that standard.

Accordingly, I would have returned this case to the District Court with the direction that it expunge all its merits findings and discussion and then proceed to perform its prescribed function of ruling, on the *administrative* record only, whether Walsh's denial of benefits was arbitrary or capricious.

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[3] The District Court relied on a Ninth Circuit divided en banc case which, contrary to Third Circuit jurisprudence, required *de novo*, not deferential, review. *See Kearney*, 175 F.3d 1084. In *Kearney*, a lawyer with a heart condition who played several sets of tennis every weekend, car-raced up to 120 miles per hour and had medical opinions that he could return to work, contested the cessation of his disability policy payments. *Id.* at 1086. The District Court accorded *de novo* review and ruled in favor of the insurance company. *Id.* at 1086-87. A fractured en banc court reversed, approving de novo review but finding a material disputed fact. *Id.* at 1090, 1093.

II

Although the District Court purported to subscribe to the correct standard of review, a fair reading of the District Court's opinions indicates that it did not; it merely gave lipservice to the deference to be accorded to the Administrator's determinations.

Pursuant to the plain language of Reliance's policy, whether Dr. Lasser is "totally disabled" hinges on whether he can perform the "material" duties of his occupation. The relevant part of the policy provides:

> "Totally Disabled" and "Total Disability" mean * * * that as a result of an Injury or Sickness, during the Elimination Period and thereafter an Insured cannot perform the material duties of his/her regular occupation * * *.

App. at 139 (emphasis added). Critical to this analysis, is that the burden to prove materiality is on Dr. Lasser because the burden of proving coverage is always on the claimant. See *Lasser II,* 146 F. Supp. 2d at 639 (citing *Pinto,* 214 F.3d at 394 n.8). Dr. Lasser, however, submitted no evidence, no proofs, no affidavits, no witnesses, and no depositions on the issue of materiality. Indeed, the record as to this issue is barren.[4]

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[4] The majority opinion seeks to answer its own question, which it has posed as, "When he [Dr. Lasser] no longer handled night call and emergency surgeries, were they material? The District Court answered yes." Maj. op. at 387. But, as I have pointed out, it was not the function of the District Court to make such a finding. Nor is it the function of this Court to uphold such a finding when it appears in a summary judgment context.

Rather, the majority should have examined the record, as I have, for evidence of materiality as to night calls and emergencies. Had the majority done so, it would have learned, as I did, that no such evidence exists — and it is that evidence that the Reliance policy requires.

Moreover, the burden of proof as to materiality rests with Dr. Lasser and the majority opinion's purported clarification respecting the burden of proof does not change that prescription. *See* maj. op. at 391.

Despite the silence of the record regarding materiality, the District Court nevertheless held that Dr. Lasser had made out his burden of proof on materiality. To do so, the District Court relied principally on the diminution of Dr. Lasser's income when he discontinued emergency and on-call duties. *Id.* at 639-40. The majority, too, finds this diminution in income to be controlling. Yet, it must be remembered that during the period of time (from September 1996 to December 1997) that Dr. Lasser was "totally disabled," he was attending to all his office functions and tasks and he was performing scheduled (elective) surgery. At the same time, he was collecting total disability benefits from Reliance.

The District Court also relied on the various medical reports from cardiologists, although they merely stated that Dr. Lasser should not perform "emergency" and "on-call" work — not that those functions were "material" to his occupation of orthopedic surgeon. *Id.*

Reliance, on the other hand, presented evidence on the issue of materiality. Reliance looked to the duties of a general surgeon as defined in the Dictionary of Occupational Titles ("DOT") from the United States Department of Labor. "Emergency" and/or "on-call" work are not included in material duties. Dr. Lasser has presented no evidence to the contrary.

Furthermore, the DOT is a recognized authority in the vocational industry. See, e.g., *Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 272-73 (4th Cir. 2002) (DOT is an objectively reasonable tool for determining the *material* duties of an occupation; a "general job description of DOT, to be applicable, must involve comparable duties but not necessarily every duty.") (emphasis added).

Similarly, the District Court gave no deference whatsoever to Reliance in its use of a labor market survey. This study provided direct evidence that "on-call" and "emergency" duties-the only restrictions which Dr. Lasser's physicians proscribed-

were not material. Dr. Lasser provided no vocational studies nor, as I stated earlier, any other evidence which contradicted Reliance's evidence on materiality.

Moreover, the use of such vocational studies in eligibility for disability benefits is an accepted practice in this Circuit. See, e.g., *Russell v. Paul Revere Life Ins. Co.*, 288 F.3d 78, 79, 82 (3d Cir. 2002) (labor market study which identified jobs within the claimant's occupation that did not require travel, contravened plaintiff's contention that he remained disabled because he could not work extended hours and travel, which his current position required).

All of this evidence stands unrebutted by Dr. Lasser. Again, the appropriate standard of review is whether or not Reliance was arbitrary and capricious in determining that Dr. Lasser *failed to meet his burden of materiality*, that is: that Dr. Lasser could not perform the material duties of his regular occupation. Nowhere in this record is there evidence that "emergency" and "on-call" tasks — the only work which Dr. Lasser was told he could not perform — are material to Dr. Lasser's every day occupation. Although I am sympathetic to Dr. Lasser's financial and medical difficulties — as I am sure the members of the majority are too — such sympathy cannot substitute as evidence that "emergency" and "on-call" work are *material* to the occupation of an orthopedic surgeon.

Furthermore, I find it troubling that Dr. Lasser presented no vocational study, nor any evidence from experts in the field, or even evidence from the members of his own office or himself, to support his contention that these tasks were in fact material. In particular, there has been no evidence as to whether his three partners could handle and would respond to the practice's on-call and emergency duties, although such circumstances could lead to a diminution of income for Dr. Lasser. There was also no evidence in the record that Dr. Lasser could not perform scheduled elective surgery, as well as all other office procedures and tasks.

III

The majority, I sense, has fallen into the same pattern of analysis employed by the District Court. Instead of addressing and assessing the basis, the rationale and the evidence which led to the Administrator's determination denying benefits, and then giving appropriate deference to that determination, the majority discusses the evidence as if it was subjected to *de novo* review after trial. In doing so, it draws its own conclusions and substitutes its own judgment as to who and what is to be believed.

Instead of looking to the evidence of materiality — (there is none) — or the evidence of whether "emergency" and "on-call" procedures are material — (the evidence is uncontradicted that they are not) — the majority opinion reviews the District Court record as if it arose from a non-jury fact-finding trial. That, I suggest, was the error the District Court fell into and it is compounded by the majority of this panel.

I also find that the majority's preoccupation with the definition of "regular occupation" misses the mark. Here, we are concerned only with the policy's definition of "total disability" which concentrates on *material* aspects of Dr. Lasser's practice. The majority relies on the Second Circuit's decision in *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243 (2d Cir. 1999), even though that case is distinguishable inasmuch as the standard of review there, unlike here, was *de novo*. The majority further strains to justify the term "regular occupation" by relying on a Fourth Circuit unpublished opinion, *O'Bryhim v. Reliance Standard Life Ins. Co.*, 188 F.3d 502 (Table), 1999 WL 617891 (4th Cir. 1999) (unpublished *per curiam*). *See* maj. op. at 386. A Fourth Circuit unpublished opinion under no circumstances can be considered precedential by this Court. In doing so, the majority opinion ignores the claim evaluation framework established by the very language of the Reliance policy that it quotes: First, the claimant's condition is evaluated. Next, the claimant's regular

occupation is evaluated and the material duties thereof are defined. Finally, the claimant's condition is compared against the material duties determined to be required in his regular occupation. It appears that Dr. Lasser, the District Court, and now this Court would end the inquiry after just the first step.

IV

Another example of the District Court's failure to defer to Walsh's determinations revolves around Dr. Lasser's continuing to work while receiving disability payments of about $6,000 a month, as well as Dr. Lasser's return to work after his benefits were discontinued.

Reliance argues that Dr. Lasser cannot be totally disabled because in December 1997 he returned to "full-time" unrestricted work, *including* "emergency" and "on-call" duties, without consequence to his health. *See* App. at 263. Reliance further contends that it was reasonable because none of the doctors stated that he would be incapable of performing a full-time schedule and Drs. Burke and Field specifically evaluated Dr. Lasser as being capable of full-time work.

The District Court concluded, and the majority here agrees, that because Dr. Lasser risked *future* heart attacks due to the *stress from on-call and emergency duties* — which on this record cannot be characterized as material — his continuing to work after the termination of his insurance benefits nevertheless is evidence of his "total disability." In particular, the District Court focused on the fact that he risked his health, against the express recommendations of his doctors, by returning to those duties out of economic necessity. *Lasser II,* 146 F. Supp. 2d at 626 n. 5, 627, 630. But, without satisfying the policy's condition of inability to perform tasks material to his occupation, I cannot agree that Dr. Lasser, who was working in his office and performing elective surgery, was "totally disabled."

The Eighth Circuit has addressed this issue of relating economic necessity to total disability in a context similar to Dr. Lasser's. In *Galman v. Prudential Ins. Co. of America,* 254 F.3d 768 (8th Cir. 2001), the Eighth Circuit held that a claimant cannot assert total disability when he has returned to work, regardless of whether he returned to work out of "economic necessity" after an initial denial of benefits while awaiting the results of his administrative appeal. *Galman,* 254 F.3d at 771-72. Galman was a trial attorney who suffered from coronary artery heart disease, with a history of, *inter alia*, two prior heart attacks. He based his disability claim, in part, on the risk of aggravating his heart condition due to the stress of work. After the claim was denied, Galman returned to work full time asserting that the denial "forced him to return to work for financial reasons." *Id.* at 771. The court rejected his claim for benefits. *Id.* at 772.

The majority implies that Dr. Lasser was unable to work a forty-hour week, and thus was disabled. But the majority misapprehends our jurisprudence. An insurer is not arbitrary and capricious merely because it relies on other medical opinions that result in a denial of coverage; it is only arbitrary if such decision was "clearly not supported by the evidence in the record or the administrator has failed to comply with the procedures required by the plan." *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 41 (3d Cir. 1993); *see also, e.g.*, *Orvosh v. Program of Group Ins. for Salaried Employees,* 222 F.3d 123, 129 (3d Cir. 2000); *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1148-49 (7th Cir. 1998) (a plan's decision, if reasonable, must be affirmed even if the claimant presents an opposite position). Here, Reliance has fully complied with all established procedures and the Administrator's record is replete with evidence supporting the Administrator's decision.

V

Moreover, the District Court's and the majority's reliance on the issue of "stress" does not do credit to their analyses.

Once again, I consider the evidence from the administrative record through the lens of deference. Under this deferential standard, it is clear that the District Court, and then the majority, erred.

First, it is undisputed that none of the doctors who supported the disability claim ever stated with any degree of medical certainty the increased risk to Dr. Lasser of returning to full-time employment. Reliance's policy does not insure against *future* disability — only *present* disability. A doctor or other expert who determines that a patient is disabled based on the possible *future* effects of stress should have to quantify that risk so that the ERISA decision maker can determine if it constitutes a present disability. Thus, an opinion that Dr. Lasser's venous graft may not survive another five years does not satisfy the condition of Reliance's disability policy — a policy which requires that Dr. Lasser be unable to perform the material duties of his occupation at this time. To illustrate: I, as a judge, may go blind in five years — but if I am not blind *now*, that possibility cannot be deemed to render me *presently* disabled.

I think we all recognize that stress, while it may affect cardiac patients, does not necessarily incapacitate them, or prevent them from successfully returning to, and performing, stressful jobs, *i.e.*, Vice President Dick Cheney. *See, e.g., Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793, 796, 798-99 (8th Cir. 2002) (plan not arbitrary and capricious in denying benefits, even where the claimant's doctor declared him disabled based on the exacerbating factor of stress); *Gooden v. Provident Life & Accident Ins. Co.*, 250 F.3d 329, 335 n.8 (5th Cir. 2001) (dismissing claimant's complaint that his insurance company failed to account for his doctor's concern of the stress associated with his job).

Based on the administrative record, it was not arbitrary and capricious for Reliance to determine that Dr. Lasser was not "disabled" based on any risk of relapse from stress. Indeed, stress tests subsequent to his heart attack in July 1996 did not reveal any chest pain or EKG abnormalities during cardiac testing, only a "very small myocardial infarction" which was "very small and probably clinically insignificant." App. at 208. Three cardiologists rated Dr. Lasser at a Functional Class I level for physical capacity on the New York Heart Association Functional Classification System, which level designates "[p]atients with cardiac disease but with no limitation of physical activity." *Lasser II,* 146 F. Supp. 2d at 626. Dr. Aldrich's March 25, 1998 report states: "I do not disagree [with Dr. Burke] that by all objective criteria Dr. Lasser is doing very well at this point in time" and also reports that Dr. Lasser "does not currently have any symptoms, his examination is negative with respect to the cardiovascular system, and his stress test from April of 1997, as well as the stress test performed by Dr. Burke showed good exercise capacity * * *." App. at 222. Dr. Raska's August 5, 1998 report confirmed Dr. Lasser's cardiovascular fitness as "excellent," his cardiac condition as stable and further stated that patients with a New York Heart Association Functional Class I level typically have "an overall low risk of cardiovascular morbidity or mortality." App. at 229.

VI

I believe that the District Court should have determined, on the *established administrative record,* whether the Administrator abused his discretion and was arbitrary and capricious in determining at least the following matters:

(a) Did Dr. Lasser meet his burden of establishing the material tasks and aspects of his practice?

(b) Are emergency surgeries and on-call duties material parts of Dr. Lasser's functions as an orthopedic surgeon?

(c) Could and did Dr. Lasser perform elective (scheduled, not emergency) surgery as material procedures of his occupation?

(d) Could Reliance's policy as drawn take into account future disabilities that Dr. Lasser may suffer or was it limited to only the current or present disability which Dr. Lasser may or may not have?

It is these matters with which the District Court had to concern itself in determining whether the Administrator's denial of benefits was arbitrary and capricious. By failing to do so, I believe the District Court erred.

One last word on this subject. I am troubled by the District Court's reliance on the Ninth Circuit's *de novo* standard in *Kearney*. *See supra* note 3. While *Kearney* may have its advocates, and I cannot help but note that the Ninth Circuit en banc court was severely divided, we have yet to depart from established review standards in ERISA and summary judgment cases. To my mind, the District Court's abrogation of both these standards in favor of a *Kearney* review, rings a warning bell that cannot be ignored.

Had the District Court conducted its hearing as I suggested it should, that is, confining itself only to the resolution of whether Walsh was conflicted or biased, and had the District Court then resorted to the traditional summary judgment resolution based only on the record below, I would not have raised this issue. But this is not the way this case played out, as I have noted. If we permit the review that took place in this case, I fear it will signal to district courts in the future that they are free, in similar cases, to hold merits hearings and thus to deviate from the summary judgment and *Pinto* standards.

Thus, in sum, I would reverse the District Court's judgment in favor of Dr. Lasser and remand for the District Court to properly consider this case under the summary judgment standard, giving *Pinto* deference to Walsh's determinations. As the Supreme Court just recently noted, a court must *actually*

apply the correct standard; *mere lipservice and mere citation* to a standard of review will not suffice. *See Price v. Vincent,* 123 S.Ct. 1848, 1852 (2003) (holding that the Sixth Circuit recited the correct standard of review under 28 U.S.C. § 2254(d)(1) but then did not apply it when it reviewed the double jeopardy question at issue.)

Thus, I respectfully dissent.

APPENDIX C

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

Civil Action No. 99-4131

STEPHEN P. LASSER,

Plaintiff,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Defendant.

June 13, 2001

OPINION

WOLIN, District Judge.

This matter was opened before the Court upon the complaint of plaintiff Dr. Stephen P. Lasser against defendant Reliance Standard Life Insurance Company ("Reliance") claiming that plaintiff was wrongly denied disability benefits under an insurance policy maintained by his employer. Jurisdiction is established by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132. This Court denied summary judgment and made certain other rulings governing the litigation of this matter in an Opinion and Order reported as *Lasser v. Reliance Standard Life Ins. Co.*, 130 F. Supp. 2d 616 (D.N.J. Feb. 8, 2001) (the "February Opinion").

This matter was tried to the Court on April 10, 2001. At trial, the Court heard live testimony relevant to those issues delineated in the February Opinion and certain other issues as discussed below. In addition, the Court has considered the administrative record before the claims adjudicator who denied Dr. Lasser's claim for benefits on behalf of Reliance. This Opinion constitutes the Court's findings of fact and conclusions of law, pursuant to Federal Rule of Civil Procedure 52. For the reasons set forth below, the Court will reverse the denial of benefits by Reliance and enter judgment in favor of plaintiff.

BACKGROUND

The background of this matter was set forth at length in the Court's February Opinion, familiarity with which is assumed. Pursuant to its policy of insurance, Reliance acts as the insurer/underwriter and claims administrator of the ERISA-governed, employee benefit plan maintained during periods relevant to this matter by Townsquare Orthopedic Associates. Dr. Lasser was an orthopedic surgeon employed by Townsquare Orthopedic, a small, four-doctor practice.

Dr. Lasser has had a heart condition for many years. He has undergone bypass surgery and suffered a myocardial infarction, referred to in this Opinion by the more colloquial "heart attack." The decision to deny Dr. Lasser's application for disability benefits was made by Richard Walsh, Esq., Reliance's Manager of Technical Services. The evidentiary record in this matter consists of written materials used by Mr. Walsh in making his decision and Mr. Walsh's testimony at trial.

As this Court explored at length in its February Opinion, this case presents two discrete fields of inquiry. First, under the Third Circuit's decision in *Pinto v. Reliance Standard Ins. Co.*, 214 F.3d 377 (3d Cir. 2000), this Court must decide whether the insurer's decision to deny benefits was tainted by a conflict of interest. Deciding this question is necessary to determine where on *Pinto*'s "sliding scale" of arbitrary and capricious

review this case belongs; the greater the evidence of conflict, the less this Court may defer to the insurer's determination. Second, once the correct standard of review has been determined, the Court must apply it to the claims administrator's decision and decide whether, on the record before him, the administrator was arbitrary or capricious in denying the benefits.

Because of the nature of this action, not all evidence may be considered on all issues. Any evidence properly before the Court may be considered to decide whether Reliance was influenced by a conflict of interest. When it comes to determining whether the denial of benefits was or was not arbitrary and capricious, however, the inquiry must be limited to that evidence before the claims administrator. *See generally Lasser,* 130 F. Supp. 2d at 627-30. The only witness to testify at trial of this matter was Mr. Walsh. Much of his testimony was relevant solely to the conflict-of-interest question and extrinsic to his denial of Dr. Lasser's benefits. Other testimony, however, concerned the extent of Walsh's knowledge when he made the benefits determination and the various internal rules and conventions under which he operated.

Walsh's understanding and these rules and conventions, while not part of the paper record, nonetheless form part of the matrix within which Walsh made the decision affecting Dr. Lasser. Their soundness, *vel non*, provides important insight into whether and how Walsh may have abused his discretion. Evidence of what Walsh considered and how he considered it is thus part of the "record" in the broader sense. Moreover, Walsh's testimony regarding the basis for the denial of benefits substantially mirrors the arguments of Reliance's counsel, as might be expected given that Walsh is himself an attorney. On this basis, the Court will consider certain of Walsh's trial testimony in relation to the underlying question of whether the denial of benefits was arbitrary and capricious. The Court has been careful, however, to treat only the actual evidentiary

record before the claims administrator as dispositive of the ultimate question of whether denial of the benefits was an abuse of discretion under the policy.

DISCUSSION

1. Determining the Standard of Review

As noted above and as explored extensively elsewhere, *Pinto v. Reliance Insurance* held that where an insurer of an ERISA plan is also acting as a claims administrator a structural conflict of interest[1] exists between the company's duty to administer claims fairly and its obligation to pay those claims from its own coffers. It is established in this case that the Townsquare Orthopedic Associates ERISA plan granted discretion to Reliance to administer benefits. The United States Supreme Court has held that when an ERISA plan grants such discretion to a fiduciary, a denial of benefits may be reviewed in the federal courts only for abuse of that discretion, or under the functionally equivalent arbitrary and capricious standard of review. *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989).

The Court recites the well-known law articulating this standard because it provides a base of reference for what follows. Under the arbitrary and capricious standard, "the district court may overturn a decision of the Plan administrator only if it is 'without reason, unsupported by substantial evidence or erroneous as a matter of law.'" *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993) (quoting *Adamo v. Anchor Hocking Corp.*, 720 F. Supp. 491, 500 (W.D.Pa. 1989)); *accord Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 439 (3d Cir. 1997). "A decision is supported by

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[1] This conflict has also been referred to by this Court and the Court of Appeals as the "inherent conflict" or "structural bias" problem. *E.g.*, 214 F.3d at 389. Although "structural conflict" is perhaps the most descriptive, the Court will continue its prior practice of using these terms interchangeably.

'substantial evidence if there is sufficient evidence for a reasonable person to agree with the decision.'" *Courson v. Bert Bell NFL Player Retirement Plan,* 214 F.3d 136, 142 (3d Cir. 2000); *Daniels v. Anchor Hocking Corp.,* 758 F. Supp. 326, 331 (W.D. Pa. 1991). Thus, the scope of review is narrow and "'the court is not free to substitute its own judgment for that of the [administrator] in determining eligibility for plan benefits.'" *Id.* (quoting *Lucash v. Strick Corp.,* 602 F. Supp. 430, 434 (E.D. Pa. 1984), *aff'd,* 760 F.2d 259 (3d Cir. 1985)).

The *Pinto* Court held that "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." 214 F.3d at 378. The Court of Appeals left to consideration of the individual case exactly how "heightened" the form of arbitrary and capricious review must be. The lower courts must consider factors suggesting self-interest on the part of the claims administrator. These factors will guide the courts' selection of the appropriate point along the "sliding scale" of more and more intrusive scrutiny of administrators' decision. *Id.* at 379.

The Court of Appeals acknowledged that it was giving birth to "some form of intermediate scrutiny that has no analogue in this field," 214 F.3d at 392, and questions remain regarding its application. One is whether a threshold increase in the level of scrutiny is required in all cases in which a claims administrator operates under an inherent conflict of interest, or whether *Pinto*'s sliding scale might, in the appropriate case, slide all the way back to fully deferential arbitrary and capricious review. The Court does not refer to those cases in which an insurer's structural conflict problem is directly ameliorated by considerations such as an experience-rated premium relationship with its insured. *See* 214 F.3d at 388 n.6. The question is, where does the "sliding scale" start in the archetypal case of an insurer/claims administrator for which

every granted claim travels, dollar-for-dollar, to the company's bottom line.

The Eastern District of Pennsylvania has found that *Pinto* requires heightened arbitrary and capricious review in all cases where an inherent conflict is present. *Cimino v. Reliance Standard Life Ins. Co.*, 2001 WL 253791, *3 (E.D. Pa. March 12, 2001). References in post-*Pinto* Court of Appeals decisions support that view. *Goldstein v. Johnson & Johnson*, 251 F.3d 433, 441 (3d Cir. 2001) (heightened arbitrary and capricious review properly applied where design of plan creates conflict of interest or where specific facts exist indicating bias); *Orvosh v. Program of Group Ins. for Salaried Employees of Volkswagen of Am., Inc.*, 222 F.3d 123, 129 n.7 (3d Cir. 2000) (in *Pinto*, "we decided that a heightened standard of review applies where the same entity both funds and administers an ERISA plan"). In *Oslowski v. Life Ins. Co. of N. Am.*, 139 F. Supp. 2d 668 (W.D. Pa. 2001), the district court found that in the absence of extrinsic evidence of conflict or bias, an administrator in a structural conflict situation was entitled to a "moderate degree of deference."

Passages from *Pinto* itself may be read to suggest that some increase in scrutiny is mandated in all cases of inherent conflict. Indeed, the Court of Appeals stated bluntly, "we believe that a higher standard of review is required when reviewing benefits denials of insurance companies paying ERISA benefits out of their own funds." 214 F.3d at 390; *see also id.* at 378 ("[W]e hold that, when an insurance company both funds and administers benefits, it is *generally* acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review.") (emphasis added). The introduction of the sliding scale concept later in the *Pinto* opinion complicates the simplicity of these pronouncements. Moreover, this Court recognizes, as did the *Pinto* court, the esoteric nature of the entire sliding-scale approach. *See id.* at 392-93. These caveats notwithstanding, the Court believes that traditional, unmodified

arbitrary and capricious review can no longer be appropriate in the paradigm case of an insurer with a true, structural conflict, even where other indicia of conflict or bias are absent.

This being said, it is also clear that the beginning point of *Pinto*'s sliding scale of heightened arbitrary and capricious review lies but a modest distance from the original standard, and that, absent other evidence of bias, the Court should engage in no more than a modicum of additional scrutiny. In February, this Court wrote:

> Thus, at trial, the Court will consider all the evidence relevant to the degree of conflict and the resulting location on *Pinto*'s range of heightened arbitrary and capricious review, and the Court will render a plenary determination of those issues at that time. At this stage of the proceeding, the level of intrusiveness with which the Court will review the denial of benefits is still an open question. The facts that emerge may confirm the Court's view as already expressed. These facts may, however, move the Court either further along the scale towards *Pinto*'s "high degree of scepticism" or, assuming the problems already identified are satisfactorily explained, back towards a more deferential standard of review.

130 F. Supp. 2d at 626. The Court, it is true, did posit a standard of review it considered appropriate based on the facts then before it. The Court was careful, however, as the quoted passage shows, to make clear that this standard of review was a tentative one.

The foregoing discussion was necessary for the following reason. Based upon the trial testimony in this matter, the Court finds no evidence of overt bias exhibited by Walsh, the claims administrator. It will be seen below that the Court finds that the denial of benefits was erroneous, and, indeed, so wrong as to require reversal under any standard. It would be redundant to

repeat each of these errors here only to discuss them again later in connection with the merits. Suffice it to say that Walsh's testimony has convinced the Court that the specific shortcomings identified in this Court's February Opinion were due to errors of analysis and not bias in favor of his employer. The instances raised by counsel leave Dr. Lasser's allegations of active self-dealing not proven.

As discussed, this leaves the Court at the mild end of the heightened arbitrary and capricious scale, subjecting the benefits decision to only that extra scrutiny required by the structural conflict arising from the insurer acting as its own claims administrator. For lack of a more precise formulation, the Court adopts that of the Western District of Pennsylvania and finds that a "moderate degree of deference" is the proper standard of review.

2. The Merits of the Decision

Each of the issues in play in this case is governed by the Reliance policy. It provides that:

> "Totally Disabled" and "Total Disability" mean, with respect to [Physicians and Administrators], that as a result of an injury or Sickness,[2] during the Elimination Period and thereafter an insured cannot perform the material duties of his/her regular occupation;
>
> (1) "Partially Disabled" and "Partial Disability" mean that as a result of injury or Sickness an insured is capable of performing the material duties of his/her regular occupation on a part-time basis or some of the material duties on a full-time basis. An insured who is Partially Disabled with be considered Totally Disabled, except during the Elimination Period;

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[2] It has not been contested that Lasser's heart condition is the result of sickness, as defined in the policy, and the Court will consider this element of coverage established.

This is an occupational disability policy, which insures against loss of income due to the inability of insureds to engage in their regular or usual occupations. It is to be distinguished from a general disability policy, which provides benefits only to insureds who cannot engage in *any* occupation for which they are reasonably suited. *Smith v. Equitable Life Assur. Soc. of the United States*, 67 F.3d 611, 616 (7th Cir. 1995).

Within the question of the substantive merits of the administrator's decision again lie two, discrete areas of inquiry. First, the parties dispute what activities Dr. Lasser can or cannot do. Second, the parties dispute what activities constitute the "material duties of [Dr. Lasser's] regular occupation." Again, familiarity with many of the details of the record evidence on these points, discussed at some length in the February Opinion, is assumed.

a. The Medical Evidence

Reliance's error in connection with this first issue, what Dr. Lasser is medically capable of doing, falls into four, inter-related categories. The first concerns defendant's persistent reliance on a Dr. Burke, an independent cardiologist who examined Dr. Lasser for Reliance. The second involves the weight placed on the New York Heart Association Functional Class scale, which purports to measure a patient's cardiac health based on the patient's physical capacity. Third, and related to the previous two, is Reliance's treatment of the issue of occupational stress. The last is directed to Reliance's assessment of the connection between risk, in this case risk of a heart attack, and capacity to perform.

The failings of Dr. Burke's analysis of Dr. Lasser's condition were explored in the February Opinion. In summary, Dr. Burke's examination of Dr. Lasser involved a treadmill test and other examination techniques calculated to reveal what Dr. Lasser's physical capacity was at the moment of the examination. Dr. Burke gave it as his professional opinion that

"this individual does not demonstrate any cardiovascular disability." Three other reviewing cardiologists and two treating cardiologists provided written opinions which appear in the record of this case. Every other doctor involved came to a substantially different conclusion from Dr. Burke. Regarding the utility of Dr. Burke's treadmill stress test, Dr. Raska wrote that it "is absolutely not the standard of care" and "not known to be accepted as conventional to any clinical cardiologist." Dr. Lubow stated, "The fact that the test was not done in a manner accepted by all cardiologists raises a question about the qualifications of [Dr. Burke] who denied the patient's disability." RSL469.[3]

Important omissions in Dr. Burke's opinion were identified by the other doctors. Most prominently, by focusing on transient physical capacity, Dr. Burke failed to appreciate the risk to Dr. Lasser posed by occupational stress. Indeed, there is no mention of this issue in Dr. Burke's report. By ignoring the question of occupational stress in relation to Dr. Lasser's cardiac health and what professional duties it is medically reasonable for him to perform, Dr. Burke is at odds with the formidable weight and, indeed, unanimity of the other cardiologists opining on this case.

In addition, key points were missing from Dr. Burke's analysis, leading other doctors to conclude that Dr. Burke had failed adequately to review the medical record before him. For instance, Dr. Aldrich pointed out that Dr. Burke failed to notice a lack of improvement between thallium stress tests taken in August of 1996 and April of 1997 because Dr. Burke's report did not mention the August 1996 test. RSL464. Dr. Burke stated that he reviewed records of a catheterization performed in October 1996, but Dr. Lubow points out that there was no

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[3] This citation is to the administrative record submitted as a trial exhibit and admitted into evidence. The page number and "RSL" prefix refers to the bates number sequence of the documents in the record.

catheterization on that date, but only one done in July 1996 which revealed important problems with Dr. Lasser's heart, problems not mentioned by Dr. Burke. Both Drs. Lowell and Lubow complained that Dr. Burke missed or ignored medical records indicating that Dr. Lasser's bypass graft had failed and that Dr. Lasser's heart had significant and deteriorating anatomical abnormalities.[4] RSL466, RSL469.

Dr. Burke, in a rebuttal letter solicited by Reliance, wrote: "It is not important what an individual's anatomical profile is as long as the risk factor prevention program is maximal and that function as far as can be determined * * * is entirely within normal limits." RSL115. Dr. Burke made this statement in support of his conclusion that the opinions of Drs. Lubow and Aldrich were not "germane" to "the essential question of what is this individual's functional capacity in terms of being able to work." *Id.*

Here is revealed the flaw in Dr. Burke's approach. Dr. Burke believes that if a patient can, at any given moment, perform at a certain level and if risk factors are minimized as much as possible, then other problems, such as a failed and deteriorating bypass, occupational stress, and other factors pointing to a risk of a catastrophic medical event in the future, are "not important" and indeed, not even "germane" to the question of disability. It is obvious even to the lay person that a person might minimize risk factors for a heart attack and yet still be so

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[4] Dr. Lowell wrote:

> No mention is made in Dr. Burke's letter of the presence of a failed bypass graft to the main vessel of Dr. Lasser's heart. This main vessel is now fed somewhat surreptitiously [*sic*] by another bypass graft which at 12 years of age is statistically likely to begin to fail in the not distant future. Additionally, this vessel is compromised by a 60% obstructive plaque. This critical anatomic point ought to have played a role in Dr. Burke's determination because of the likely role stress will play in Dr. Lasser's future health.

RSL466.

sick that engaging in certain activities presents a medically unacceptable danger of future injury or death. This holds true even though, on any given day, that person might engage in such activities with no noticeable ill effect.

As will be seen below, this error has infected Reliance's entire treatment of the case. Yet, even on its own terms, Dr. Burke's reasoning is circular. He qualifies his position of no disability with the proviso, "so long as risk factor prevention is maximal." But the risk factor prevention cited by all five of the other doctors includes reducing Dr. Lasser's occupational stress by eliminating emergency surgery and on-call duties. Dr. Fields opined that, with these restrictions, Dr. Lasser could work forty hours a week, but the other doctors called for both the substantive restrictions on his duties *and* less than full-time working hours.[5] Dr. Burke's claim that with "maximal" risk prevention Dr. Lasser is not disabled does not respond to the points his colleagues raised and, in fact, strains credulity.

The testimony of Walsh reveals the extent to which Reliance relied upon the New York Heart Association Functional Classification system. This system has four levels of functionality for measuring the capacity for exercise of patients with cardiac disease. Level-four patients are unable to exercise at all without physical discomfort. Level one designates "[p]atients with cardiac disease but with no limitation of physical activity." RSL252. The system also contains a scale of grades A through E denominated "therapeutic classification." Grade-A patients need have no restrictions on physical activity; grade E must be at complete rest.

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[5] *See* RSL183 (Dr. Raska) (reduced schedule "absolutely necessary"); RSL464 (Dr. Aldrich) (any increase in work load beyond the reduced hours prior to the termination of benefits "would substantially increase his risk for future cardiac events"); RSL466 (Dr. Lowell) (cannot fulfill duties of "full time" orthopedic surgeon); RSL469 (Dr. Lubow) (citing change in schedule as part of medically indicated stress risk reduction).

Dr. Burke rated Dr. Lasser as functional class one and therapeutic class A. Dr. Raska, perhaps the most vehemently critical of Dr. Burke's work, also rated Dr. Lasser as functional class one, but therapeutic class C ("ordinary physical activity should be moderately restricted and * * * more strenuous physical efforts should be discontinued"). RSL252. Dr. Fields, in response to Walsh's question, also rated Dr. Lasser as class one. RSL92. It is clear that Walsh considered the classification of fundamental importance. *See* Tspt. at 22, 29-30. Indeed, Walsh inquired of Dr. Fields whether stress could be discounted as a risk factor in patients classified as level one. RSL79.

Dr. Fields responded that stress could not be discounted, writing that "In essence, functional class and exercise performance can predict general prognosis but can not predict future cardiac events." RSL93. Dr. Fields went on to emphasize the need to apply such general guidelines of cardiac care to the individual case. *Id.* Regarding Dr. Lasser's partially successful and aging bypass, Dr. Fields stated "cardiovascular prudence restricts isometric activity, competitive sports, and other acute emotional or physiological stress events from which the patient cannot immediately withdraw." *Id.*

It is apparent from the text of the New York Heart Association classification form in the record that it does not address the issue of emotional and/or occupational stress. RSL252. The functional classifications are directed solely to the patient's physical exercise capacity. Even the therapeutic classes, which in any event were not mentioned by Walsh, address only whether limiting physical activity is necessary. Nothing in the New York Heart Association classifications provides explicit guidance regarding psychological stress, and Dr. Field's letter rejects the inquiry of Walsh seeking scientific evidence linking a class-one rating to a reduced role of stress as a heart attack risk factor.

As will already be clear, the medical evidence overwhelmingly supported the fact that occupational stress

posed a serious risk of further deterioration of Dr. Lasser's heart condition and of another heart attack. Speaking generally, Dr. Fields wrote: "[B]oth physical and emotional stress are identified triggers of acute myocardial infarction." RSL92. Dr. Aldrich said, "[S]tress is a well-documented risk factor not only for the development of coronary artery disease itself, but within that context to the precipitation of a myocardial infarction." RSL463. Likewise was Dr. Raska:

> Stress regardless of exercise tolerance is a recognized independent risk factor for recurrent coronary artery disease * * * [T]here are multiple studies in both humans animals and in the laboratory which demonstrate that stress causes flux in the level [of] catecholamines in the circulation which have been shown to be a precipitant of acute myocardial infarction and sudden death. RSL83-84.

The doctors were no less emphatic in relating the general proposition to Dr. Lasser's case. Dr. Lubow wrote, "However, the biggest risk to [Dr. Lasser] is physical and emotional stress that cannot be controlled easily. * * * Such stress is accepted by all experts as a significant risk factor in coronary artery disease." Dr. Lowell: "I contend that a less stressful environment would contribute to his graft longevity and subsequently his life." RSL466. Dr. Aldrich states pointedly that, with increased occupational stress, "Dr. Lasser's risk of myocardial infarction with all of its attendant morbidity and mortality will rise significantly." RSL463. Finally, Dr. Lasser provided to Reliance the report of his treating psychiatrist documenting the fact that Dr. Lasser experienced stress stemming from his return to an increased practice following the denial of his disability benefits.

In the backdrop of the other doctors' opinions, it is notable that Dr. Burke's report does not address occupational stress at all. The letter dated April 13, 1999, from Reliance purporting to set forth the reasons for denying Dr. Lasser's administrative

appeal also makes no mention of the question of stress nor of its implications for Dr. Lasser. Finally, Walsh's testimony shows what weight was afforded the evidence of the danger of stress. This passage is illustrative:

> THE COURT: [quoting from Dr. Lieb's report] "I firmly believe that return to the reduced work schedule recommended by his cardiologist to lessen job related stress would be in his best interest and reduce the risk of jeopardizing his health and life."
>
> What weight, if any, did you give to that statement of Dr. Lieb?
>
> WALSH: Again, I didn't give it a great deal of weight, to be quite honest with your Honor. I hate to sound harsh but I would suggest that reducing stress would be in everybody's best interest.
>
> Tspt. at 46.

Elsewhere, Walsh's answers to questions clearly intended to elicit what weight he placed on the issue of stress were simply evasive. *See* Tspt. at 80-84. It appears that Walsh was prepared to at least entertain the possibility of stress in connection with emergency and on-call duties, tspt. at 83, although Reliance has challenged even that finding. Plainly, Walsh did not consider occupational stress to be a significant factor in relation to number of hours worked excluding those specific activities. Tspt. at 81, 83. Elsewhere, he states again: "Everybody has stress in their life and I certainly understood that when I made the decision." Tspt. at 84.

Of course, everybody does not have Dr. Lasser's heart condition. Walsh's references to the stress in "everybody's" life or that "everybody" would benefit from reduced stress are superficial at best. Juxtaposition of these references with Walsh's other testimony, *e.g.*, that "physical capacity played a great deal into my determination," tspt. at 81, other references throughout the transcript, and the witness's demeanor lead to a

virtually inescapable inference. Dr. Lasser's supposed physical capacity drove Walsh's decision to deny benefits and substantially displaced consideration of the risk posed by occupational stress, which played a markedly less important role in the claims analysis. *See also, e.g.*, tspt. at 75. Courts have found in the context of analyzing a claim of cardiac disability for Social Security insurance benefits that it is reversible error to focus on physical capacity to the exclusion of emotional stress associated with work. *Schlabach v. Secretary of Health, Educ. & Welfare,* 469 F. Supp. 304, 315 (N.D. Ind. 1978). The relative lack of weight Walsh placed on occupational stress in assessing Dr. Lasser's disability claim cannot be squared with the medical evidence and is unreasonable on the facts of this case.

Finally, the Court cannot accept Walsh's analysis of risk of future harm in relation to present disability under the terms of the disability policy. It is a basic tenet of insurance law that an insured is disabled when the activity in question would aggravate a serious condition affecting the insured's health. See *Stark v. Weinberger,* 497 F.2d 1092, 1098-99 (7th Cir. 1974); *Oppenheim v. Finch,* 495 F.2d 396, 398 (4th Cir. 1974); *Stillwell v. Sullivan,* 1992 WL 401971, *6 (D. Kan. Dec. 30, 1992). As noted in the Applemans' treatise, "The insured is considered to be... disabled where it is impossible for him to work without hazarding his health or risking his life." 1C Appleman, *Insurance Law & Practice* § 651 at 241 (1981). In fact, this proposition is sufficiently well-settled that in many jurisdictions it travels under the name of the "common care and prudence rule." E.L. Kellett, Annotation, *Continuation of Work as Affecting Finding of Total or Permanent Disability within Insurance Coverage,* 24 A.L.R.3d 8, § 3(a) (1969); *see, e.g., McGowan v. Orleans Furniture Inc.,* 586 So. 2d 163, 166 (Miss. 1991); *John Hancock Mut. Life Ins. Co. v. Poss,* 154 Ga. App. 272, 267 S.E.2d 877, 880 (1980).

Insureds with heart conditions or who have experienced heart attacks provide an obvious context for the application of these principles. E.L. Kellett, Annotation, *Heart or Vascular Condition as Constituting Total or Permanent Disability within Insurance Coverage,* 21 A.L.R.3d 1383, § 3 (1968). Where medical prudence requires a cessation of work activity, the insured is disabled; insurers have failed to convince courts that risk of a heart attack in the future does not constitute a present disability. *Pompe v. Continental Cas. Co.,* 119 F. Supp. 2d 1004, 1010 (W.D. Mo. 2000) ("[S]uch an approach would force patients with serious health risks to cripple themselves, or even risk death, in order to be considered disabled. * * * The law is not so harsh.") (citing *Herring v. Canada Life Assur. Co.,* 207 F.3d 1026 (8th Cir. 2000)).

This is true even though the insured may be capable of physical activity. *Honeysucker v. Bowen,* 649 F. Supp. 1155, 1162 (N.D. Ill. 1986). Clearly the risk of a heart attack may be a disabling factor even though the claimant can sit, stand, or ambulate. *Schlabach,* 469 F. Supp. at 314; *Avemco Life Ins. Co. v. Luebker,* 240 Ark. 349, 399 S.W.2d 265 (1966).

Paraphrasing rather than quoting at length, Walsh testified on direct examination that he was aware that some of the doctors had linked stress to an increased risk of heart attack. *See* Tspt. at 32. Walsh complained, however, that the doctors had not quantified the amount of increase. Tspt. at 32 ("[I]s it increased to 51% or is it increased to 5%? It wasn't clear."). In response to counsel's question, Walsh stated that if risk of a heart attack were "more likely than not," then the disability benefits would not have been denied. Tspt. at 32-33.

Counsel, in Reliance's submissions, has pursued this line of argument as further reflected in this exchange with Walsh at trial.

> Q: Now, does this policy anywhere in the definition of disability or anywhere in the policy at all, does it say

anything about paying benefits for prospective disabilities?

A: No, it doesn't.

Q: Potential disabilities?

A: No, it doesn't.

Q: Risk of relapse?

A: No.

Tspt. at 44-45. But even Walsh had previously conceded that a greater than 50% chance of a heart attack would qualify as a disability. The fact is that Walsh's testimony leaves no room for doubt that he was imposing his own assessment of the necessary probability of a serious medical event before a risk *in futuro* would be considered a disability.

It was not required that the cardiologists state a numeric percent of probability of a heart attack for them to conclude that, in their professional opinion, certain occupational stress posed a medically unacceptable risk of a heart attack. Nor was Walsh entitled to substitute his own, more-likely-than-not probability threshold for the judgment of the doctors. Moreover, as the authorities cited above establish, a medically unacceptable risk of a future heart attack and possible death may constitute a present disability under the policy, notwithstanding the suggestion of Walsh's testimony and counsel's arguments that Dr. Lasser's condition constitutes only an uninsured risk of harm in the future.

On April 13, 1999, Walsh wrote to Dr. Lasser's counsel denying the appeal from Walsh's earlier termination of benefits. This stands as Reliance's final denial letter and written opinion of the claims administrator. RSL45-48. In fact, the portion directed to the medical issues is not long and the entire letter is couched as a rebuttal to the arguments posed by counsel rather than as a comprehensive exposition of Reliance's grounds for denying the claim.

The most substantive point in Walsh's letter is the following: "Whether or not Dr. Burke's assessment was accurate, the information provided by every other physician involved in this case support our conclusion that Dr. Lasser can work on a full-time (40 hour per week) basis provided he avoid being on call and performing emergency surgery." RSL47. As noted above (*see supra* footnote 5) and in this Court's prior Opinion, this statement is in error. Only Dr. Fields opined that Dr. Lasser could work a forty-hour week. In its post-trial submission, Reliance has slightly modified its position, claiming only that no doctor specifically disapproved a forty-hour work week. While the other doctors did not state a maximum number of hours Dr. Lasser can work, the proposition that he can work full-time cannot fairly be reconciled with the overwhelming majority of the medical opinion available in this case as set forth in the doctors' opinion letters.

Walsh goes on to state that "It should be noted that even these restrictions [*i.e.* no emergency or on-call duties] are questionable given the fact that Dr. Lasser has demonstrated the ability to perform these activities since the termination of his benefits." RSL47-48. Indeed, it is clear from Walsh's testimony that Dr. Lasser's return to on-call and emergency duties heavily influenced his decision to deny further benefits. *See* Tspt. at 24, 43, 44, 45-46, 83-84. Reliance persists in this view in its arguments before this Court. Defendant's Trial Brf. at 6 ("The fact that he was working proved that he was no longer disabled.").

Obviously, where a disability consists of a danger of future negative health events, post-diagnosis employment does not necessarily negate the finding of disability. *Stark v. Weinberger,* 497 F.2d 1092, 1100 (7th Cir. 1974). In the context of a disability where the claimant hazards his well-being by returning to work against his doctors' recommendations, return to work should not affect the benefits determination. 1C Appleman, *supra*, § 651 at 242-45; *Kellett,*

supra, 24 A.L.R.3d 8, § 3(a); *see also Levinson v. Reliance Standard Life Ins. Co.,* 245 F.3d 1321, 1326 n.6 (11th Cir. 2001) ("We doubt that Levinson's status as a full-time employee constitutes evidence that he was able to perform the material duties of his occupation on a full-time basis."); *General Am. Life Ins. Co. v. Yarbrough,* 360 F.2d 562, 566 (8th Cir. 1966); *Stillwell,* 1992 WL 401971 at *6-*7; *Johnson v. State Farm Mut. Auto. Ins. Co.,* 342 So. 2d 664 (La. 1977). This is particularly true where a claimant is forced to work by economic considerations. *See Johnson,* 342 So.2d at 667; 10 Lee R. Russ & Thomas F. Segalla, *Crouch on Insurance 3d* 147:13.[6]

Dr. Lasser has testified by affidavit that he returned to on-call and emergency duties out of economic necessity caused by the termination of his benefits. No evidence has appeared to rebut this. The medical opinions in the record explained that the fact Dr. Lasser had not suffered a cardiac event following his return to work meant nothing in terms of the risk he was running nor the possibility that Dr. Lasser's condition would likely deteriorate as a result. Walsh's statement in his letter that Dr. Lasser's return to an increased schedule makes "questionable" the existence of Dr. Lasser's disability shows his misunderstanding of the nature of the disability involved. *See also* tspt. at 83-84 (Walsh testifying that Dr. Lasser "demonstrated the capacity to perform all of the other duties of

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[6] Cases such as *Kaufman v. Provident Life & Cas. Inc. Co.*, 828 F. Supp. 275 (D.N.J.1992), *aff'd*, 993 F.2d 877 (3d Cir. 1993), holding that continuous and regular employment will preclude a finding of disability are distinguishable. There is no suggestion in *Kaufman* that the claimant's return to work posed a risk to his health nor that he did so contrary to the express advice of his doctors. Moreover, Kaufman's return to work was obviously more complete and continuous than Dr. Lasser's. Claimant Kaufman earned over $600,000 per year while asserting he was disabled and he only reduced his activities, the district court found, to increase his prospects of continuing to receive disability benefits. 828 F. Supp. at 286.

his occupation and subsequently performed even those duties that you found too stressful").

Miscellaneous other testimony by Walsh leads the Court to question further whether he ever correctly understood the gist of Dr. Lasser's case that he was disabled. For example, Walsh testified that he gave Dr. Lieb's psychiatric report "very little weight," because it was the only psychiatric report offered, because Dr. Lieb's treatment was only for a three-month period, and because there was no claim that Dr. Lasser had been taking psychotropic medicines. Tspt. at 45-46. However, the point of Dr. Lieb's opinion was not to make a claim for a psychiatric disability. Dr. Lieb's opinion was offered to establish the link between Dr. Lasser's normal duties as a fully- engaged orthopedic surgeon and the emotional stress Dr. Lasser was experiencing.

The reasons Walsh gave for discounting Dr. Lieb seem completely to miss the thrust of his opinion, focusing instead on whether there is evidence of a severe or long-term psychiatric condition. Indeed, elsewhere Walsh testified that he had no knowledge of whether on-call and emergency surgery would be stressful to Dr. Lasser. If Walsh had correctly understood the import of Dr. Lieb's opinion, this void would have been filled.

In sum, the Court finds that Walsh's conclusion that Dr. Lasser was not disabled cannot be reconciled with the medical evidence before him. Walsh's continued reliance on Dr. Burke's opinion and on the New York Heart Association functional capacity scale is plainly error. Neither authority, as demonstrated, even considers the issue of emotional stress as a risk factor for a heart attack.

In the face of the strongly worded and unanimous opinions of the other cardiologists, Walsh was not free to disregard occupational stress, clearly the primary threat to Dr. Lasser's cardiac well-being. The connection between Dr. Lasser's occupation and that stress was established by Dr. Lieb's opinion

as supplemented by the treating and consulting cardiologists. For Walsh to discount this weight of medical opinion on the ground that "reducing stress would be in everybody's best interest," tspt. at 46, was an abuse of discretion.

To hold that the medical evidence supported a return to a forty-hour week is likewise clearly wrong. Disregarding Dr. Burke who saw no reason for any limitation at all, only Dr. Fields approved a forty-hour week, "restricting this to out-patient and consultative orthopedics." RSL93. Dr. Lasser's treating cardiologist and three other cardiologists made it clear that a forty- hour week was contrary to their advice. During the administrative review process, questions were raised regarding the impartiality of Drs. Raska and Lubow because they came from the same practice group. Although counsel for Reliance continues to raise this issue, Walsh's final decision letter considered and dismissed this concern and termed Dr. Raska's opinion "comprehensive" and "objective." RSL47.

Under the arbitrary and capricious standard, the decision-maker may choose to credit some evidence over other evidence. The decision-maker may not, however, adopt what is so clearly the minority view, dismissing this substantial weight of medical authority for a contrary position, without at least some rational explanation for doing so. Even less so under the heightened arbitrary and capricious review applicable in this case may Walsh ignore the views of Drs. Raska, Lubow, Aldrich and Lowell. Thus, no reason is given for dismissing, for example, Dr. Raska's opinion that a reduced schedule is "absolutely necessary to maintain this patient's health" or the numerous similar opinions in the record. Walsh's and Reliance's repeated assertions that all of the doctors favored a return to a forty-hour week are unreasonable and, indeed, inexplicable. Certainly these bare assertions do not justify crediting only Dr. Field's opinion.

b. The Vocational Evidence

Reliance's decision to deny Dr. Lasser's benefits is best seen as resting on two grounds in the alternative. First, Walsh found, unreasonably in the view of the Court, that Dr. Lasser's heart condition did not prevent him from working a full-time schedule or from performing on-call or emergency duties. In the alternative, assuming that Dr. Lasser was disabled from on-call and emergency duties, Walsh ruled that these activities were not "material duties of [Dr. Lasser's] regular occupation." It will be noticed that this alternative argument takes as an underlying premise that a forty-hour week is still possible for Dr. Lasser, a point the Court has rejected *supra*.

It is, however, common ground that if providing emergency and on-call services are material duties of Dr. Lasser's regular occupation, and if Dr. Lasser is disabled from these activities, then Dr. Lasser is entitled to benefits under the policy even if he is otherwise able to work full-time. This is due to the provision in the policy that a disability permitting the insured to perform only a portion of his material duties on a full-time basis constitutes a total disability for the purposes of the policy. It is also common ground that Dr. Lasser's regular occupation was as an orthopedic surgeon and that he performed emergency and on-call services before being diagnosed with his disability. Much of the energies of counsel were directed to disputing whether emergency and on-call services are a material duty for an orthopedic surgeon.

Walsh has made it clear that he brings no personal knowledge to the question of what the "regular occupation" of an orthopedic surgeon might involve, what might or might not be considered emergency or on-call services, or whether such services are a material duty of an orthopedic surgeon. See Tspt. at 34, 101. The transcript contains the following exchange.

> THE COURT: * * * let's say the doctor goes to his office five days a week * * * and your kid eight years

> old is playing on the playground, falls and breaks his arm, and you take him to the doctor at noon and the arm has to be x-rayed, set, cast put on. Is that an emergency?
>
> THE WITNESS: I don't know if that's classified as an emergency or not.
>
> THE COURT: Well, did you give any thought to it as to whether it's an emergency or not?
>
> THE WITNESS: As I said, I thought about elective surgery in general. No I didn't think about that particular situation.
>
> THE COURT: If that were to be considered an emergency, would that in any way influence your decision?
>
> THE WITNESS: I don't believe it would.

Tspt. 28-29. Walsh testified that the information upon which he formed his opinion in this case was limited to the Department of Labor's Dictionary of Occupational Titles ("DOT") and the survey taken by an outside vocational consultant. Tspt. at 34.

The Court has already addressed the shortcomings in Reliance's analysis of the vocational issues. In its February Opinion, the Court found that the DOT is "far too blunt an instrument to be instructive as to the material duties of an orthopedic surgeon." 130 F. Supp. 2d at 624. The DOT describes the occupation of a surgeon as evaluating patients and performing operations. As noted, "Orthopedic Surgeon" is identified as an "Undefined Related Title," "specializ[ing] in correction or prevention of skeletal abnormalities utilizing surgical, medical, and physical methodologies." RSL261.

The DOT does not disclose whether or in what proportion an Orthopedic Surgeon deals with emergencies. Indeed, as Walsh's testimony quoted above suggests, there is no

information as to what would even be considered an emergency. Walsh refers to the possibility of elective surgery, but the DOT is silent regarding when, if ever, elective surgery is performed by Orthopedic Surgeons. (Interestingly, the DOT does indicate that a surgeon's working conditions involve performance under stress.)

Presumably the DOT's "skeletal abnormalities" includes broken bones. In fact, common knowledge as supplemented by a generic dictionary suggests that such injuries are the bread and butter of a normal practice for an orthopedic surgeon. *See* American Heritage College Dictionary 965 (3d ed. 1993) (including treatment of "injuries and skeletal disorders" in definition of orthopedics). As demonstrated above, Walsh did not know and did not consider whether treating a routine fracture was properly classified as an emergency. By logical implication, therefore, Walsh did not know or consider whether treating such an injury was a material part of an orthopedic surgeon's job. This is entirely consistent with his reliance upon the DOT, which, of course, provides no information on this point.

Walsh testified that the DOT was a mainstay of the long-term disability insurance industry. Tspt. at 115. This Court is not the only tribunal to find this authority lacking. *See, e.g., Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 253 (2d Cir. 1999); *Pinto v. Massanari,* 249 F.3d 840 (9th Cir. 2001) (DOT definition of hand packager was "generic" and did not adequately capture "varying abilities and job knowledge" required of persons with this job description) (internal quotation omitted); *Paige v. Bowen,* 695 F. Supp. 975, 980-81 (N.D.Ill. 1988); *see also Wright v. Sullivan,* 900 F.2d 675, 684 (3d Cir. 1990) (absence of job listing in DOT shows DOT not comprehensive, not that job does not exist). However, whether or not Walsh appreciated the shortcomings of the DOT's occupational definition, he testified that he decided to commission a survey to determine whether emergency and on-

call duties were material duties of an orthopedic surgeon. The Court has already expressed its opinion of the survey in general terms in its February Opinion. Further study of the record and the testimony of Walsh only confirms the Court's prior view that this survey was fatally flawed in its execution and in Reliance's interpretation of it. In sum, the survey added nothing to the information base upon which Walsh relied for his decision.

The core question of the survey was: is it "reasonable to expect that an Orthopedic Surgeon can practice in this field" when disabled from performing emergency or on-call duties. *See* 103 F. Supp. 2d at 624 (survey quoted in full). It is notable that the question does not ask whether emergency and on-call duties form a significant part of a typical orthopedic surgeon's practice. The question defines neither what is meant by "practice in this field" nor emergency or on-call duties. The vocational expert employed by Reliance opined that such a definition would be redundant to the intended recipients of the survey. RSL53. The omission is important, however, in light of the professed lack of knowledge on the part of the decision-maker, Walsh. This lack of knowledge and the lack of specifics in the survey question mean that Walsh was forced to rely upon the results of the survey as a kind of net opinion, without permitting him to weigh by any logical process the validity or relevance of the answers he received.

This fact makes it only the more unfortunate that the questions in the survey were ill-framed. What "reasonable" may mean in this context is unclear. The phrase "practice in this field" only muddies the waters further. A respondent could well have believed that the hypothetical disabled orthopedic surgeon could practice in some capacity in the field of orthopedics, but not necessarily as an orthopedic surgeon.

Indeed, one respondent took the trouble to point out this ambiguity, writing: "In your example, you are describing a physician who is not an orthopaedic surgeon, but might be

considered an orthopaedist." RSL150. Other respondents may have construed "reasonable" to mean that it would be conceivable, or practicable, or even merely desirable that a disabled doctor could still practice "in this field" despite the stated restrictions. The central problem is that the question does not directly ask for the respondents' empirical observation of the real-world situation. Walsh's reliance on the survey, with its yes-or-no answers unadorned by any definition or explanation of exactly what duties the respondents are considering, was not well taken.

Reliance maintains that the follow-up questions remedy the lack of real-world connection for the central question posed. These ask the respondents to rank from "none to rare," to "occasional," or "frequent" the employment possibilities for the disabled orthopedic surgeon. Reliance believes that the frequency response "none to rare" should be considered to mean "rare" rather than none, by virtue of the positive response to the question is it "reasonable" that the disabled person could practice in the field. Finally, Reliance maintains that full-time employment as an orthopedic surgeon is implicit in the question.

The Court rejects each of these arguments. There is no reason that a respondent might not feel it would be "reasonable" for a restricted orthopedic surgeon to "practice in this field," (whatever that might mean) but that employment opportunities were in fact non-existent. Full-time employment is not implicit in the question. If, for example, the respondent believed that emergency surgery included setting a broken arm during office hours, then that respondent might well opine that a disabled doctor could practice "in the field" but that his opportunity to practice might be so reduced that full-time employment was impossible. The structure of the survey makes it impossible to rule out this possibility and Walsh, with his own professed lack of knowledge, is in no position to correct this shortcoming.

Finally, as noted previously, only fourteen responses were received from the one hundred addressees of the survey. Five stated that it was not reasonable for the restricted orthopedic surgeon to practice in the field, and thus furnished no further response. Three answered yes, but marked the "none to rare" response. Another respondent, providing further evidence of the ambiguity of the question, stated that practice in the field would be possible, but that the doctor would be limited to writing reports. As this Court has already found, this is not equivalent to practicing as an orthopedic surgeon. Thus, even of the small fraction of persons who took the trouble to respond to the survey at all, nine, or 64% could plausibly be understood to have meant that no employment opportunities for the restricted orthopedic surgeon existed at all. Stated otherwise, Reliance succeeded in securing only five responses out of the one hundred questionnaires sent indicating the employment opportunities for the hypothetical disabled orthopedic surgeon were better than "none to rare."

To maintain consistency with the February Opinion, the Court relies upon the survey responses submitted as Exhibit X to the Declaration of David J. Gruber submitted by plaintiff in opposition to the motion for summary judgment. For reasons not clear to the Court, the documents submitted at trial only contained nine responses. It may have been that Walsh only considered the nine responses while making his decision. If so, then reference to the larger number actually favors the validity of Reliance's survey.

If only the nine responses were before Walsh, then the Court finds that a fair reading of those responses would lead to either a five to four vote in favor of Reliance or an equal split in favor of Dr. Lasser, depending upon how one interprets a single ambiguous answer. *See* RSL151 (response number two). It should be noted, however, that from the more limited pool of nine responses only one ranked the job opportunities as better than "none to rare." In any event, for the reasons stated, the

mere fact of a simple majority of responses cannot justify the reliance the insurer placed upon this survey.

In fact, there are a number of grounds upon which to question the reliability of the survey, even if one accepts Reliance's mode of analyzing the results. A letter from Reliance's vocational consultant states that the recipients of the questionnaire were selected from "various orthopedic surgeons affiliated with the AMA, American Academy of Orthopaedic Surgeons — 1998 Board of Councilors Members, leading local medical schools, teaching hospitals, etc." RSL170. Did their selection, and the apparent emphasis on doctors in large institutions, influence the responses received? Why was the survey sent to only one hundred persons? Do fourteen (or nine) responses represent a statistically reliable sample of the profession; indeed, how many orthopedic surgeons are there in the United States? A document in the record titled "Overview of the American Academy of Orthopaedic Surgeons" claims the organization has 14,796 active fellows. RSL161. Yet, Walsh disavowed even a general impression of how many orthopedic surgeons practice in the United States. Tspt. at 40.

How should one interpret the small percentage of responses? Does the fact that a recipient responded mean that she or he was predisposed to agree with the premise of the survey's question and, if so, how then should one interpret the fact that 86 persons could not be bothered to reply? How can anyone know even whether the addressees of the survey questionnaire were the actual respondents, and not a member of the doctor's staff or even some unrelated party? An e-mail address is a notoriously unreliable identifier of the author of an e-mail.

None of these questions was addressed by Reliance or its outside vocational survey vendor. They are sufficiently obvious to the interested non-expert that they should have been raised by the insurer before relying upon this survey in a case of such importance. The Court finds that the survey was so obviously worthless as an authoritative measure of the material duties of

an orthopedic surgeon that Walsh's reliance upon it must be deemed unreasonable.

However, Reliance's treatment of the small number of positive responses reveals a more fundamental error in its analysis of this case. All of the evidence, both medical and vocational, is relevant only to the extent it elucidates Dr. Lasser's situation in relation to the terms of the disability policy for which Reliance accepted premiums. The policy speaks of an inability to perform the "material duties" of one's "regular" occupation. Although courts have found that this language is not as helpful as it could be, *see Scammacca v. Royal Maccabees Life Ins. Co.*, 2001 WL 493427, *1 (9th Cir. May 9, 2001) (unpublished), the Court finds it sufficiently clear in this case to have guided the discretion of the claims administrator.

"Regular occupation," on its face, refers to that occupation in which the claimant is usually engaged, as opposed to a part-time or occasional professional activity. Although the Third Circuit has ruled in cases involving the same or similar policies, those cases did not present this precise issue and our Court of Appeals has not interpreted this specific language. The Second Circuit has held that "regular occupation" in a disability policy means a job of "'the same general character as the insured's previous job, requiring similar skills and training and involving comparable duties.'" *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 252 (2d Cir. 1999) (quoting *Dawes v. First Unum Life Ins. Co.*, 851 F. Supp. 118, 122 (S.D.N.Y. 1994)). The "regular occupation" concept does not limit the insurer to considering only the precise activities of the insured's previous job. It does, however, require "some consideration of the nature of the institution at which the claimant was employed." *Id.* at 253.

Thus, in *Kinstler*, the claimant was a director of nurses in a small health care agency whose job required some physical activity. The Second Circuit held that it was proper to consider this activity as a material duty, even though a director of

nursing in a larger hospital would have an entirely sedentary position. 181 F.3d at 253. Similarly, the Fourth Circuit, in *O'Bryhim v. Reliance Standard Life Ins. Co.*, 1999 WL 617891, *8 (4th Cir. 1999) (unpublished), looked to the duties the claimant actually performed, and not to the duties of an abstract job category to determine the material duties of the claimant's "regular occupation."

This Court finds that the materiality of a given occupational duty depends upon the importance of that duty to the claimant's professional endeavors, measured as a combination of the amount of time the activity consumes and its qualitative importance to the professional mission. A duty is "material" when it is sufficiently significant in either a qualitative or quantitative sense that an inability to perform it means that one is no longer practicing the "regular occupation." The Court is careful not to limit the concept of a "regular occupation" to mean only the insured's previous job. However, the Court believes that a claims administrator considering an occupational disability claim must make some allowance for the mode in which the claimant practiced her or his profession. To rely solely on broad job classifications without some consideration for the geographical or institutional context ascribes a fungibility to the occupations of insureds that is consistent with neither reality nor the "regular occupation" formulation of the policy.

Reliance's treatment of the vocational evidence is in conflict with these basic policy fundamentals.

> THE COURT: What concerns, if any, did that cause you that only 14 out of a hundred responded and that there was submitted a lack of uniformity among the 14 that responded?
>
> WITNESS: True. It really didn't give me concerns, though, from my perspective. As I just said, we look to see if the job exists and is available. We don't

> necessarily look to see that it exists in plentiful numbers, and even with a limited number of responses, the number of them did say that it exists.

Tspt. at 40. The argument latent in defendant's counsel's direct question of Walsh further demonstrates the error in Reliance's approach.

> COUNSEL: Do you consider somebody totally disabled if you can't find them a job? In other words, is it your responsibility to find somebody a job?
>
> WITNESS: Not at all, no.

Tspt. at 39. Walsh makes it clear that neither the number of available positions nor their geographic location makes a difference to Reliance as long as the job is "available." *Id.*[7]

It is intuitively obvious that this viewpoint cannot be reconciled with the facts of this case and the language of the policy. Here the claimant practices a relatively common and familiar medical specialty in the northeastern United States. Reliance would tell disabled claimants that because a nationwide survey has discovered five members of their profession (assuming the respondents were in fact the addressees of the survey) who believe that a person with the claimant's disabilities could practice (whether in the rural South, the steppes of Nebraska or Hawaii matters not),[8] that

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[7] The Court notes that this marks an abandonment of Reliance's previous position that a majority of the survey respondents favored its position. It is clear from Walsh's testimony that if *any* respondents had favored Reliance's position, the claim would have been denied.

[8] The Court rejects the implication of Walsh's testimony that he discounted the survey respondent from Alaska, but weighed more heavily the response purporting to come from Newark's University of Medicine and Dentistry. Tspt. at 108-09. Reliance, having commissioned a survey intended to provide a statistically meaningful sampling of the orthopedic surgeon's profession nationwide, cannot change horses and advance the response of one respondent as representing the expert opinion of a local practitioner. Moreover, even acknowledging that the rules of evidence do not bind plan

such claimants can still function unimpaired in their established line of work. Reliance cannot seriously contend that this is the premise upon which their insureds purchase disability policies. Walsh believes that if at least one job with the claimant's professional title exists with the claimant's particular restrictions, the claimant can perform the "material duties" of the claimant's "regular profession." This is not a rational interpretation of the terms of the policy.

The logical flaw inherent in the vocational survey is as follows. The only issue upon which a survey such as the one conducted in this case could possibly be relevant is to determine what the material duties of an orthopedic surgeon actually are. Orthopedic surgeons would have useful knowledge on this point and could be surveyed regarding what duties they actually perform, what proportion of their time each such duty occupies, and what duties they consider central to their role in the medical profession as "orthopedic surgeons."

In addition, it would have been highly relevant if the survey had been directed to surveying orthopedic surgeons practicing in small-practice settings. It will be recalled that Dr. Lasser was one of four doctors at Townsquare Orthopedic. It is too obvious to be belabored that, in a small practice, on-call and emergency surgery may be more material to a doctor's occupation than for a practitioner at a large medical center.

On a more fundamental level, by posing a hypothetical question of whether it would be "reasonable" for an orthopedic surgeon with Dr. Lasser's restrictions to practice, and asking for the prevalence of job opportunities, Reliance and Walsh misconstrued the concept of occupational disability contained in

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administrators, for Reliance to consider an unverified e-mail response to such a flawed survey as evidence of expert local opinion would be completely unreasonable. In any event, the Court will take Walsh at his word and conclude from his testimony that he considered neither the professional affiliation nor the geographic distribution of the responses and that his opinion would not have been altered if he had. Tspt. at 109.

the policy. The following example will illustrate. One may readily imagine arcane or near-obsolete occupations, perhaps that of farrier[9] or pipe-organ builder, in which employment opportunities are exceedingly rare. The frequency or number of available openings for partially disabled farriers or pipe-organ builders has nothing to do, however, with defining the material duties of those positions. The relevant data is what tasks occupy the talents of those farriers or pipe-organ builders who are actually employed in the field, however few or numerous they might be. Should these occupations sadly die away all together, their practitioners will not be "disabled" but merely unemployed. Conversely, a farrier who cannot shoe horses cannot perform a material duty of that occupation, regardless of whether there are any job openings in the field.

In fact, Reliance's approach to vocational surveys blurs the line between occupational and general disability policies. As noted, a general disability policy only provides benefits if the claimant is disabled from any work for which he is reasonably suited by education, experience, etc. The focus is what the claimant can do and what jobs exist; the existence of any suitable job that the claimant can do will disqualify the claimant. Occupational disability, as discussed, depends upon defining the claimant's regular occupation and then evaluating whether the claimant can perform that occupation.

Consequently, in *Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan,* 85 F.3d 455, 459-60 (9th Cir. 1996), the administrator erred when it construed an occupational disability plan to deny benefits when there was work available for which the claimant was qualified and that she could do with an accommodation. This was error even though the vocational experts used the same job description as the claimant's prior position. As explained in *Ross v. Indiana State Teacher's Ass'n Ins. Trust,* 159 F.3d

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[9] One who shoes horses.

1001, 1011-12 (7th Cir. 1998), *cert. denied*, 525 U.S. 1177 (1999), in *Saffle* the administrator evaluated the claimant's employability with a modification of her duties, an accommodation that was "essentially outside of the realm of Saffle's regular job." *Id.* at 1011.

This "collapses the threshold for occupational disability into the standard for general, or permanent disability." *Saffle,* 85 F.3d at 459. The survey Reliance commissioned asked whether, after modifying Dr. Lasser's job to exclude stressful duties, work was available for him. Walsh interpreted the results of the survey to mean that if an orthopedic surgeon with these limitations could find employment in the field, he was not occupationally disabled. Left unanswered was whether those stressful duties were a material part of the duties of an orthopedic surgeon in Dr. Lasser's general type of practice.

Some of the e-mail responses to the survey suggest that the occupational/general disability distinction was blurred in the minds of the respondents as well. For instance, some said that an orthopedic surgeon unable to do emergency or on-call duty could practice, but made clear that this practice would be sharply modified from the norm. One wrote: "there are jobs out there that orthopedic surgeons can do, ie. office practice only." RSL150. Another stated: "if in community — no; academic possible." RSL149. Indeed, this result appears clearly in the narrative finding submitted with the results of the survey, which held that "this type of work setting [i.e. one without emergency and/or on-call surgery] typically involves special circumstances and these circumstances are available only rarely or occasionally * * *." RSL169.

This approach is appropriate for a general disability inquiry. It is not appropriate when considering an occupational disability claim. To repeat: the polestar is defining the "regular occupation" and whether the claimant can perform it, not whether the disabled claimant can find work. The survey does not permit one to form an opinion of what the material duties of

Dr. Lasser's (or any other orthopedic surgeon's) "regular occupation" might be. In framing the survey, Reliance and its vocational survey vendor were proceeding from an interpretation of the policy that cannot be reconciled with its plain language. *Saffle,* 85 F.3d at 459 ("As manifest in Robertson's instructions to the experts, the Committee construed 'regular occupation' as 'work available for which she is qualified that would have enabled her to work with her feet elevated' and to remain sedentary virtually always. This construction is inconsistent with the plain language of the Plan * * *.").

Thus both of the two sources of information upon which Walsh relied to inform him regarding the material duties of Dr. Lasser's occupation, the DOT and the vocational survey, were wholly inadequate. The DOT is not sufficiently detailed to provide any meaningful guidance in this case. The vocational survey was so flawed in its execution and misguided in its conception as to be worthless. Notwithstanding, Walsh disavows any general or common knowledge regarding what an orthopedic surgeon might normally do. Consequently, these two authorities form the sum of the information adduced by Reliance to answer the central question in this matter.

Here, Reliance falls back upon a procedural argument, contending that it was Dr. Lasser's burden to establish what the material duties of his regular occupation were and that he was unable to perform them. Claiming that Dr. Lasser has failed to carry this burden, Reliance maintains he has failed to prove the elements of coverage and that the company was free to deny the claim. This Court has recognized that the burden of proving coverage rests upon the claimant, and that there is no duty on the insurer's part to investigate the substantive details of a claim. *Lasser,* 130 F. Supp. 2d at 628 (citing *Pinto,* 214 F.3d at 394 n.8). Contrary to the contentions of counsel, however, the Court does not agree that without the DOT and vocational survey the record is simply empty regarding the material duties

of Dr. Lasser's occupation. On the contrary, while not as plentiful as Dr. Lasser might wish, he has adduced sufficient evidence to determine parameters of his occupation, at least with respect to emergency and on-call duties. Moreover, this evidence stands unrebutted.

The most direct of this evidence is Dr. Lasser's own affidavit. RSL473-79. Dr. Lasser testifies that he discontinued emergency and on-call duties, which, in conjunction with reduced hours, caused a dramatic drop in his income. When Reliance discontinued his disability benefits, Dr. Lasser resumed on-call and emergency surgery, although he avers that he did not resume full-time practice. Dr. Lasser did this, knowing that he risked his health, to increase his income to make up for the loss of benefits. From this, two points emerge. First, it is clear from the fact that Dr. Lasser discontinued emergency surgery and on-call duty in an attempt to alleviate stress in his occupation that these activities formed some measurable part of Dr. Lasser's practice before he became disabled. There would be little stress abatement in stopping an activity one seldom engaged in anyway. Second, the fluctuation in his income, partially cured by resuming emergency and on-call duties, indicates that these duties were significant to his overall professional activity.

Additional evidence as to the materiality of emergency and on-call duties lies in the medical opinions of the cardiologists. Walsh, testifying based upon prior experience, opined that the cardiologists' information came largely from Dr. Lasser. However, at least with respect to Dr. Lasser's treating cardiologist, it was in Dr. Lasser's interests accurately to inform him of his daily activities in order to obtain an effective program of rehabilitation. Indeed, it is based on this indicium of reliability that such out-of-court statements by Dr. Lasser would be admissible under the Federal Rules of Evidence. Fed. R. Evid. 803(4); *see* 2 John W. Strong, *McCormick on Evidence* § 277 at 247 (4th ed. 1992).

Walsh explained that he does not usually credit the statements of physicians regarding the material duties of a claimant's occupation. He claimed that, in his experience, physicians rely on what their patients claim their professional duties are, and that the company's subsequent investigation frequently shows that the physician's assumptions regarding occupational requirements are in error. Tspt. at 104-05.

The Court cannot accept this as a reasonable basis for discounting entirely the cardiologists' assessment of Dr. Lasser's regular occupation. First of all, as already discussed at length, Reliance conducted no subsequent investigation worthy of the name. Thus, the only basis for discounting the cardiologists' opinions regarding Dr. Lasser's material occupational duties is Walsh's prior experience in other cases. However, there is no basis to suppose that Walsh's grounds for discounting the medical opinions in the unspecified other cases to which he refers are any more valid than in this one. When one considers that the rationale advanced for discounting the medical testimony in those other cases may be Walsh's perceived experience in this case, the speciousness of his reasoning is apparent.

Nor is Dr. Lasser the only source of information regarding what an orthopedic surgeon is required to do. The cardiologists are, after all, medical professionals and can be expected to have some understanding of an orthopedic surgeon's duties. Dr. Aldrich wrote:

> Based on my knowledge of Dr. Lasser's cardiac condition and the demands of his profession, it is my opinion that he is disabled. I do not feel that he is capable of resuming all of the customary duties and responsibilities of an orthopedic surgeon on a full-time basis or at least that he could not do so without exposing himself to a high degree of risk.

RSL462; *accord* RSL470 ("Dr. Lasser cannot function at full capacity as an orthopedic surgeon without undue risk to his health and life.") (Dr. Lubow); RSL466 (Dr. Lasser's heart problems "have a direct and negative impact on his ability to perform the duties and responsibilities of a full time orthopedic surgeon") (Dr. Lowell); RSL93 ("I agree * * * that Dr. Lasser is not capable of resuming all of the customary duties and responsibilities of an orthopedic surgeon.").

In his opinion letter, Walsh rejected the cardiologists' opinion that Dr. Lasser was disabled from his profession, arguing that they had no expertise in vocational matters. Knowledge of the material duties of a particular profession cannot logically be limited only to members of that profession nor to experts in vocational science. Others may have a working knowledge of such matters. Moreover, Walsh's argument is seriously undermined by the fact that he was willing to assume that the consulting cardiologists were familiar with the duties of an orthopedic surgeon when he sought their opinion. Tspt. at 76-77. He directly inquired of Dr. Burke regarding those duties. Tspt. at 105-06. A claims administrator might, in his discretion, discount the opinion of a treating or consulting physician on occupational matters in favor of evidence from a vocational expert. Here, however, there exists no such alternative evidence that could rationally be considered reliable, and the evidence supplied by the doctors and directly from Dr. Lasser stands unchallenged.

Reliance is incorrect, therefore, when it argues that Dr. Lasser has failed to produce evidence in his favor on whether emergency and on-call duties were material duties of his regular occupation. It would surely have created a more compelling showing had Dr. Lasser consulted his own vocational experts. However, the circumstantial evidence of the fluctuation in his income, Dr. Lasser's own affidavit, the opinions of the cardiologists, and the evidence of causation provided by the psychiatrist Dr. Lieb cannot be disregarded. For Walsh to do so

in this case was unreasonable, particularly in light of Reliance's failure to adduce reliable vocational evidence of its own.

3. Application of the Appropriate Standard and Summary of the Holding

Much effort has been expended by the Court in stating its view of the proper application of the "sliding scale" version of arbitrary and capricious review under the *Pinto* case. While this effort was necessary and well-spent, as a practical matter it now appears to have been an academic exercise. The Court finds that even under its most deferential iteration, arbitrary and capricious review requires that the denial of Dr. Lasser's benefits be reversed. It follows, of course, that under *Pinto*'s heightened arbitrary and capricious standard, Reliance's decision cannot stand.

Disability benefits decisions are always important cases to the disabled employee. The importance of this case is only made more plain because Dr. Lasser's benefits are comparatively substantial in financial terms. Having tried this matter and having had the opportunity to evaluate the testimony and other evidence at first hand, the Court finds that the method by which Reliance analyzed this disability claim is simply not appropriate for a matter of this magnitude and importance to the persons involved.

On the contrary, Reliance has exhibited a level of care which, joined with an apparent predilection to rely on standardized techniques and categorizes, cannot be squared with the sensitive inquiry these important, *sui generis* cases require. The Court is constrained to note that Walsh is not highly experienced, having graduated from law school in 1995. It is perhaps not surprising that he should place undue weight on the DOT because it is widely used in his industry, at the expense of exercising his own critical faculties to determine whether the DOT is a useful guide in the case actually before him. Likewise, the Court finds that the numeric clarity of the New York Heart Association

classification obscured in Walsh's mind the less easily quantified but real danger of a heart attack or other cardiac injury posed by occupational stress in Dr. Lasser's work.

Walsh is plainly an intelligent and capable young lawyer. The error here is institutional; Reliance invites error by placing an attorney such as Walsh in the role of sole and unreviewable decision-maker in this type of case. And the errors here are glaring. Counsel trumpets an alleged lack of "objective proof" of Dr. Lasser's condition and claims that such proof is a "requirement" of disability coverage. Yet the anatomical problems with Dr. Lasser's heart and the undeniable fact of his heart attack are surely objective indicators of a serious problem, and even Reliance does not deny that Dr. Lasser has a heart condition. Nor, for the reasons set forth, can the Court accept Reliance's arguments that the risk of future death or serious injury posed by continued employment cannot constitute a present disability.

Of course, flaws in methodology and errors of analysis are secondary and only reveal rather than constitute direct evidence of an arbitrary and capricious decision. It is the evidentiary record that controls. Overwhelming medical opinion in this case leaves no room for reasonable argument. Dr. Lasser is seriously ill, regardless of any quibble over whether the evidence of such disability is "objective" or otherwise. Continuing with his former professional activities without substantial modification of his duties and lessening of hours worked poses a medically unacceptable risk to his well-being. The policy requires no more.

Nor does Reliance's fall-back position, that emergency and on-call duties are not material to Dr. Lasser's occupation, carry the day for the insurer. Ignoring momentarily the profound conceptual flaws in the vocational survey commissioned by Reliance, that document indicates, at most, that orthopedic surgeons practice without being able to perform such duties only infrequently or in specialized and/or administrative work

settings. What other evidence exists on the point shows that emergency and on-call duties are a substantial part of the occupation of a small-practice, orthopedic surgeon. Remaining true to the terms of the policy as covering occupational rather than general disability requires the conclusion that Dr. Lasser is disabled by virtue of his inability to perform these functions.

Reliance argues that there was at least some evidence in its favor and that this requires upholding its decision under the arbitrary and capricious standard. However, for the reasons expressed by the other doctors, Dr. Burke's opinion is too patently suspect to be considered over the numerous other contrary medical opinions. Dr. Burke's letter of rebuttal does not successfully address the flaws found in his opinion, and no other reasons have been advanced why Walsh properly could have given Dr. Burke any weight in his decision. The problems with the vocational analysis have also been explored. For the reasons expressed, the evidence adduced by Reliance simply does not support its position. It cannot, therefore, furnish sufficient grounds to uphold the decision under the arbitrary and capricious standard.

It should be obvious that, due to the special problems raised by the rule of *Pinto,* this Court has studied this record and considered the testimony of Walsh closely. The Court believes that, even under the regular arbitrary and capricious standard, the decision must be reversed. Applying the slightly less deferential standard appropriate where a structural conflict of interest exists, the Court would certainly set aside the denial of benefits. Because the Court finds that Dr. Lasser has established his entitlement to disability benefits under the policy at issue in this matter, the Court will enter judgment in his favor.

CONCLUSION

For the reasons set forth above, which constitute the Court's findings of fact and conclusions of law in this matter, the Court

finds that defendant Reliance wrongly denied Dr. Lasser the disability insurance benefits he was entitled to under the policy of insurance that is the subject of this litigation. Pursuant to the terms of that policy and as provided by the Employee Retirement Income Security Act, Dr. Lasser is entitled to those disability benefits. Judgment will be entered in Dr. Lasser's favor accordingly.

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

Civil Action No. 99-4131

STEPHEN P. LASSER,

Plaintiff,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Defendant.

February 8, 2001

REVISED OPINION

WOLIN, District Judge.

This matter was originally opened before the Court upon the motion of defendant, Reliance Standard Life Insurance Company and the cross-motion of plaintiff Stephen P. Lasser, both seeking summary judgment. This Court issued an Opinion and Order dated November 8, 2000, denying both the motion and cross-motion. Since that time, the parties have been unable to agree as to how this matter should proceed and claim that the Court's earlier decision fails to provide clear guidance on the scope of evidence that may be considered at trial or what discovery should be had by the parties. After requesting a round of letter briefs on the issue, the Court has decided to treat

these submissions as a request for leave to file a motion out of time to clarify or reconsider the November 8, 2000 Opinion.

On further review, the Court believes its earlier Opinion was sufficiently clear to convey accurately the Court's intent, and that the issues raised were, in fact, not fairly before the Court on the motion and cross-motion. However, to aid the progress of this litigation and to provide guidance to counsel on what are arguably unsettled issues in this area of the law, the Court will grant the motion to clarify or to reconsider.[1] The motion and the original motion and cross-motion for summary judgment have been decided upon the written submissions of the parties pursuant to Federal Rule of Civil Procedure 78. The November 8, 2000 Opinion and Order will be vacated and replaced with this Opinion and the Order filed herewith.

The sections on the scope of the record to be considered by the Court at trial in this matter and the nature of that trial (sections 4 and 5) are new. It will be seen *infra* that the opportunity for further reflection has caused the Court to modify other sections of its Opinion in important respects. The intent of the Court has been to clarify rather than modify. However, to the extent any inconsistencies appear with the prior Opinion, this later Opinion will control in all respects.

BACKGROUND

Except as noted, the following facts are not disputed. Plaintiff, Dr. Stephen P. Lasser, M.D., is an orthopedic surgeon employed by a four-doctor group known as Townsquare Orthopedic Associates. Dr. Lasser brings this case to recover disability benefits alleged to be owed to him by Reliance under

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[1] The Third Circuit Court of Appeals has not spoken in the wake of its opinion in *Pinto v. Reliance Ins. Co.*, 214 F.3d 377 (3d Cir. 2000), regarding the proper scope of the record to be examined and the type of trial to be conducted in cases where the rule of that decision applies. These points have received little attention yet in the district courts and remain questions of first impression for this judge.

a policy of disability insurance his employer maintains as an employee benefit. The policy defines total disability as the beneficiary's inability to perform "the material duties of his/her occupation." It is relevant to note that a partial disability (defined as either the ability to perform all of the material duties of one's occupation on a part-time basis, or less than all of the material duties on a full-time basis) is also considered a total disability for the purposes of an insured's right to receive full benefits under the Reliance policy.

Dr. Lasser has experienced trouble with his heart since the 1980's and underwent coronary bypass surgery in 1986. In 1996, Dr. Lasser suffered a myocardial infarction. At that time, Dr. Lasser's physicians discovered a number of problems with his heart and the earlier bypass. Dr. Robert F. Aldrich, plaintiff's treating physician, prescribed a treatment regimen, which included change of diet, exercise, and drug therapy. Significantly for this matter, Dr. Aldrich also prescribed reduced stress in Dr. Lasser's professional and personal life.

In September of 1996, Dr. Lasser returned to work on a markedly reduced schedule. His patient load was reduced 50%. He was no longer "on-call" at night or on weekends, nor did he perform emergency surgery. He removed himself from participation in the management of the group. His compensation fell from approximately $28,000 per month to approximately $6,000.

In December 1996, Reliance approved Dr. Lasser's application for long-term disability benefits under Townsquare Orthopedic's policy. This approval was based, at least in part, upon Dr. Aldrich's statement on Reliance's Physician's Statement form that Dr. Lasser could return to work on a limited basis only. However, in June 1997, Reliance began to request additional proof of Dr. Lasser's disability. Reliance solicited another statement from Dr. Aldrich. Reliance also retained Dr. William M. Burke, who examined plaintiff and subjected him to a treadmill exercise tolerance test. Reliance

reviewed the Department of Labor's Dictionary of Occupational Titles (hereinafter "DOT"), and determined the physical requirements of an orthopedic surgeon.

Reliance terminated Dr. Lasser's benefits by letter dated December 8, 1997. In the letter, Reliance relied primarily upon Dr. Burke's findings that Lasser did not demonstrate "any cardiovascular disability," that his prognosis "is excellent," and that his physical capabilities show the capacity to work "without restriction."

Dr. Lasser sought a review of the benefits termination, and submitted a number of reports from medical experts. These doctors supported the position that occupational stress, as opposed to physical exertion, was dangerous to Dr. Lasser's condition. These reports were also critical of both Dr. Burke's conclusions and his methodology. Reliance sought a second independent opinion from Dr. Karel Raska which was also critical of Dr. Burke. Following receipt of Dr. Raska's report, Reliance claims to have discovered a conflict of interest, in that Dr. Raska is affiliated with the same practice group as one of the medical experts retained by plaintiff. Reliance then sought the opinion of a Dr. Field. The details of these second and third opinions obtained by Reliance will be discussed below. They do not unequivocally support Reliance's position.

In addition to the DOT, Reliance also commissioned a study from a vocational expert to determine whether a doctor who cannot perform emergency surgery and cannot be "on-call" could, nonetheless, perform the material duties of the occupation of an orthopedic surgeon. The vocational expert performed a survey of professionals in the field and concluded that an orthopedic surgeon could practice in this field despite the listed limitations, "however, this type of work setting typically involves special circumstances and these circumstances are available only rarely or occasionally." Following a review of the survey results by an in-house

vocational expert, Reliance affirmed the termination of Dr. Lasser's benefits.

Although still operating on a reduced schedule, Dr. Lasser has been taking some "on-call" duty, wearing a pager, and performing emergency surgery. He has testified by affidavit that he is forced to do this by financial hardship following the termination of his benefits by Reliance.

DISCUSSION

1. Summary judgment and the standard of review

The standard for deciding a motion for summary judgment has been stated many times by this Court and will be addressed only briefly here. Summary judgment shall be granted if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *see Hersh v. Allen Prods. Co.,* 789 F.2d 230, 232 (3d Cir. 1986).

Whether a fact is "material" is determined by the substantive law defining the claims. *Id.* at 248; *United States v. 225 Cartons,* 871 F.2d 409, 419 (3d Cir. 1989). Of course, "at the summary judgment stage the judge's function is not himself to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 249 (1986).

The substantive law governing this matter is the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, pursuant to which this lawsuit is brought. *See* 29 U.S.C. § 1132(a)(1)(B) (participant or beneficiary may bring suit to recover benefits due under an ERISA-governed benefits plan). In *Firestone Tire & Rubber Co. v. Bruch,* the United States Supreme Court held that a claim regarding a denial of benefits is reviewed under an arbitrary and capricious standard if "the benefit plan gives the administrator or fiduciary discretionary

authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. 101, 115 (1989).

The Third Circuit only recently acted to dispel confusion created by certain questions left unanswered by the Supreme Court in *Bruch,* in a case concerning the same defendant-insurer at bar. *See Pinto v. Reliance Standard Life Ins. Co.,* 214 F.3d 377 (3d Cir. 2000). The policy at issue in *Pinto* is conceded to be the same as the policy owned by Dr. Lasser's employer with respect to the role of the Plan Administrator. In an earlier, unreported decision, the Court of Appeals held that this policy confers discretion on the fiduciary, thus triggering *Bruch's* deferential standard of review. *Pinto v. Reliance Standard Life Ins. Co.,* 156 F.3d 1225 (3d Cir. 1998).

In *Bruch,* the High Court suggested that deference might, however, not be appropriate where the fiduciary had an conflict of interest with respect to the decision of whether to award benefits. 489 U.S. at 115. In *Pinto,* the Court of Appeals addressed the problem of the inherent conflict, where the fiduciary's decision to award benefits will come at a direct cost to the fiduciary itself. The inherent conflict problem is presented in its classic form where an insurance company both administrates plan benefits and pays those benefits from its own funds. *Bruch,* having identified the problem, conspicuously failed to offer guidance in evaluating the benefits decisions of such conflicted fiduciaries.

From a variety of solutions employed in various federal circuits, our Third Circuit chose the "sliding scale" approach. This is termed a "heightened arbitrary and capricious standard," 214 F.3d at 392, in which the level of scrutiny of the fiduciary's decision "'is a range not a point * * * [it is] more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is.'" *Id.* (quoting *Wildbur v. ARCO Chem. Co.,* 974 F.2d 631, 638 (5th Cir. 1992) (alterations in original)). Acknowledging that bias is unlikely to be revealed by an evidentiary "smoking gun," the *Pinto* court directs the

district courts to examine the facts of the particular case, *id.* at 392, and to "ratchet upward" the standard of review where those facts suggest the fiduciary was acting in its own self-interest. *Id.* at 394.

In *Pinto,* the Court of Appeals found several suggestive features requiring a heightened level of scrutiny. First, the fiduciary reversed its earlier grant of benefits without a significant change in the factual record upon which it had based its earlier decision. *Id.* at 393. Second, the fiduciary's written decision employed a self-serving selectivity in the evidence it considered. *Id.* at 394. Third, Reliance failed to follow the recommendation of its own personnel to grant benefits pending further testing, suggesting to the Court of Appeals that the "default position" was to withhold benefits. *Id. Pinto* teaches that the considerations that guide the essentially sui generis inquiry in one case cannot uncritically be transferred to another case. However, this Court is guided by the kind of factors examined and the weight afforded them by the Court of Appeals to remove the standard of review in that case to "the far end of the arbitrary and capricious range." *Id.*

The Court will be careful not to permit the question of facts indicating a conflict of interest and the appropriate standard of review to blur its assessment of the ultimate merits of the case. The only question presented by the pending motion and cross-motion is whether a rational fact-finder could find for one, the other, or either of the two parties to this action. Deciding the appropriate level of review is merely an antecedent step to this issue, itself an intermediate point on the way to the ultimate resolution of this controversy.

2. Factors favoring heightened arbitrary and capricious review

The Court is satisfied that the record of this case discloses at least two significant problems with Reliance's handling of Dr. Lasser's claim for benefits. These problems require scrutiny of

the fiduciary's decision to be substantially increased. The first concerns Reliance's use of expert medical opinion, and the second concerns the vocational experts' data and conclusion regarding the material tasks of an orthopedic surgeon.

Dr. Lasser attempts to bring his case in line with *Pinto* by noting that Reliance reversed itself after first granting the benefits. By itself, the Court would attach little weight to this fact. The policy gives Reliance the right periodically to review continued eligibility for benefits. Necessarily, this includes the ability to supplement the medical record. One suggestive fact is undeniable. Kathy Young, R.N., employed by Reliance to review the medical records of disability claimants, substantially revised her assessment of Dr. Lasser in October 1997, based upon his successful performance on an exercise test, and lack of recent symptoms. The Court finds this of limited significance, because Nurse Young was not the final decision maker, and because the distinction between Dr. Lasser's ability to deal with occupational stress and his ability to do physical exercise may have been beyond her level of expertise.

Nurse Young recommended an independent medical examination, which led to Dr. Lasser's visit to Dr. Burke. It is here that the difficulties commence for Reliance's handling of the case. Dr. Burke found that plaintiff was capable of working without restriction, and that plaintiff demonstrated no cardiovascular disability. Dr. Burke's treadmill exercise test showed "excellent exercise tolerance" as related by Reliance. No mention was made either in Reliance's termination letter or in Dr. Burke's report of the issue of occupational stress that featured so prominently in Dr. Aldrich's earlier reports. Indeed, Reliance stated that the attending physician's findings "were not supported by the objective medical findings."

Dr. Aldrich responded with the first of many subsequent criticisms of Dr. Burke's opinion, by letter dated March 25, 1998. The point was not, Dr. Aldrich maintained, that Dr. Lasser could perform well on a treadmill. The relevant point

was that stress is a well-known risk factor for precipitating myocardial infarction. Dr. Aldrich stated that the therapeutic goal was to preserve the level of physical function identified by Dr. Burke. Were he to return to a stressful occupation, Dr. Aldrich wrote, "I believe that the risk of myocardial infarction with all of its attendant morbidity and mortality will rise."

Having already rejected Dr. Aldrich's opinion, it is not surprising that Reliance should have declined to reconsider based upon his March 1998 letter. However, the second independent opinion obtained by Reliance, from Dr. Raska, is even more critical of Dr. Burke. The following excerpts from his report are telling:

> As part of his independent evaluation by Dr. William Burke, the patient underwent a repeat stress test utilizing a protocol not known to be accepted as conventional to any clinical cardiologist.
>
> * * *
>
> Stress regardless of exercise tolerance is a recognized independent risk factor for recurrent coronary artery disease.
>
> * * *
>
> A reduced stress work environment and schedule is absolutely necessary to maintain this patient's health.
>
> * * *
>
> Reviewing Dr. Burke's independent assessment, it is clear that his analysis was, in fact, sloppy.
>
> * * *
>
> It is clear to me that Dr. Burke's analysis of Dr. Lasser's case was sloppy and, in fact, inaccurate. His treadmill exercise protocol is absolutely not the standard of care. Additionally, his review of records appears to have been

> inadequate. Finally, his therapeutic recommendations do not meet the American Heart Association guidelines.
>
> Thus, in conclusion, Dr. Lasser should be considered permanently partially disabled. His cardiovascular anatomy is known and although no demonstrable ischemia can be shown on a stress test at present, his prognosis for the long- term is not excellent as Dr. Burke describes. If the patient's saphenous vein graft fails, he is at risk for significant myocardial infarction. Clearly, stress can play a role in the precipitation of such an event.

This report, obtained by Reliance itself as an independent second opinion, devastates the credibility of Dr. Burke's opinion. The issue of stress as opposed to physical exercise tolerance was emphasized by Dr. Aldrich and, more emphatically, by Dr. Raska. Again, Dr. Burke never even addressed this issue.

Dr. Lowell, an associate of Dr. Aldrich, had performed a cardiac catheterization and angioplasty on Dr. Lasser. Dr. Lowell also provided an opinion and observed that Dr. Burke had failed to note that the vein graft on Dr. Lasser's heart was not as post-operative records had indicated. Dr. Lowell characterized the bypass as "failed" and wrote that "[i]t is clearly just a matter of time before Steve has problems with his vein graft to the anterior and lateral surfaces of his heart." The main vessel in his heart is "compromised by a 60% obstructive plaque." "This critical anatomical point ought to have played a role in Dr. Burke's determination because of the likely role stress will play in Dr. Lasser's future health." In fact, Dr. Burke's report makes no mention at all of the physiognomy of Dr. Lasser's heart.

Dr. Lasser also consulted an independent physician, Dr. Lawrence A. Lubow. Dr. Lubow's opinion parallels that of doctors, Raska, Aldrich and Lowell. Again, Dr. Burke's work

was sharply criticized. Dr. Burke's mis-citation of the records he claims to have examined led Dr. Lubow to question whether Dr. Burke looked at the records at all. Dr. Lubow emphasized Dr. Burke's failure to note the unsuccessful nature of Dr. Lasser's bypass surgery. Dr. Lubow noted statistical evidence that the vein graft might not last more than another three to five years. Finally, Dr. Lubow reiterated the danger posed by occupational stress.

Reliance seems to have been unwilling to concede the gathering weight of medical opinion. Instead, Reliance claims to have discovered a conflict of interest in Dr. Raska, based upon the fact that he belongs to the same practice group as Dr. Lubow. This in itself is questionable. Although their association might lead these doctors to agree with each other, the fact that both Lubow and Raska were selected as independent consultants by both sides hardly shows a pre-disposition to bias toward either Reliance or Dr. Lasser. Further, Dr. Lubow testifies by affidavit that he was unaware that Dr. Raska had been retained by Reliance and that he never discussed his opinion in the case with Dr. Raska until after both physicians had made their reports.

In any event, Reliance's final choice, a Dr. Fields, essentially endorsed the conclusions of the earlier reports. Dr. Fields noted that exercise performance can support a general prognosis, but cannot predict future cardiac events. While hedging on the state of scientific certainty in the cause and effect relationship between stress and heart attack, Dr. Fields wrote that "[c]ardiovascular prudence" restricts acute emotional or physical stress from which the patient could not immediately withdraw. Dr. Fields concurred with the other doctors that Dr. Lasser should not be on call or perform emergency duties. He wrote that Dr. Lasser "is not capable of resuming the customary duties of and responsibilities of an orthopedic surgeon." A forty-hour work week was permissible, Dr. Fields opined, if

limited to out-patient and consultative orthopedics "with some elective surgery."

In its letter affirming the denial of Dr. Lasser's benefits, Reliance stood by the opinion of Dr. Burke. In the alternative, however, Reliance also argued that each of the other doctors had found only that Dr. Lasser should not be on-call or perform emergency surgery. Maintaining that on-call status and emergency surgery are not material tasks of the occupation of an orthopedic surgeon, Reliance claimed that each of the doctors found that Dr. Lasser could work full-time at his occupation and still observe the above limitations. As to the several statements in the medical opinions that Dr. Lasser was disabled from his occupation as an orthopedic surgeon, Reliance took the position that these doctors had exceeded their area of expertise by opining on issues of vocational science.

In fact, Reliance was in error when it stated that each of the doctors opined that Dr. Lasser could work full-time provided he avoided on-call status and emergency surgery. Actually, Dr. Fields is alone in stating that Dr. Lasser could work full-time (not including Dr. Burke who saw no reason for any limitation). Indeed, Dr. Lubow specifically cites long hours as a source of risky occupational stress and the desirability of a "change in schedule and lightening of his duties" in addition to the elimination of emergency and on-call duties.

The Court believes that the manner in which Reliance has treated the medical record in this case requires the Court to travel a considerable distance along *Pinto*'s sliding scale and substantially to reduce the deference otherwise afforded to the fiduciary's termination of benefits. Continuing to defend Dr. Burke's conclusions is very difficult to reconcile with the assumption that Reliance performed a fair review of the record. Reliance professed to need yet more medical opinion following the reports of Drs. Lubow and Raska, who, though affiliated with each other, were independent of either of the parties.

An insistence on more evidence in the face of medical opinion favoring the beneficiary must at some point suggest that the insurer's conflict of interest has affected its benefits determination. Here, while the issue is not completely clear cut, rejecting the Raska and Lubow opinions adds to the circumstances one may fairly deem "suspicious." Finally, Reliance's assertion in the affirmance letter that all of the doctors supported a return to a forty-hour work week is simply a misstatement of the record.

In sum, with due regard for the unique facts that each case must inevitably present, the Court feels that the situation here presents a variant of the factor identified in *Pinto* concerning selective use of the evidence. Compelling medical evidence exists that the occupational stress of full-time employment as an orthopedic surgeon is unacceptably dangerous for Dr. Lasser. Reliance's argument that Dr. Lasser has recently engaged in full-time practice (including on-call status and emergency surgery) without ill effects proves nothing. It is surely not reasonable to require that Dr. Lasser suffer another heart attack before receiving benefits. The concern over occupational stress stands completely unrebutted in the medical record. Reliance's focus on Dr. Lasser's exercise tolerance constitutes selective use and self-serving use of the evidence, suggesting that its decision to deny benefits was tainted by its inherent conflict of interest.

Rather than tackling the medical evidence frontally, Reliance attempts to redirect the argument toward the definition of Dr. Lasser's occupation. The insurer argues that the occupation of orthopedic surgeon does not necessarily include emergency surgery and on-call status as material tasks. If the occupation exists in the national economy as a full-time position without these two, extra-stressful tasks, Reliance argues, then Dr. Lasser is not disabled within the terms of the policy. Of course, this leaves aside the issue of whether Dr. Lasser can work a forty-hour week even with these limitations, a position taken only by

Dr. Fields. Even as stated, however, Reliance's methodology is problematic in this area as well.

Reliance relies heavily on the Department of Labor's DOT definition of the occupation. Whatever may be said for the persuasive effect of this publication in other fields, the Court finds it far too blunt an instrument to be instructive as to the material duties of an orthopedic surgeon. The pages from the DOT submitted to the Court only purport to define the occupation of "Surgeon." Orthopedic surgeon is mentioned merely as an "Undefined Related Title." Few would doubt that emergency surgery is a necessary task for the position of an emergency room surgeon and that the position is supremely stressful. On other hand, a plastic surgeon might well perform only elective surgery during regular hours. The DOT is simply silent regarding where on this continuum the occupation of orthopedic surgeon might lie. Likewise the survey performed by Reliance is patently flawed. The study was performed by sending approximately 100 e-mails to orthopedic surgeons across the country, asking them

> In general, in your experience is it reasonable that an Orthopedic Surgeon can practice in this field if one:
>
> A. Cannot perform "on-call" duties; do night calls, or carry a pager
>
> ____ NO ____ YES
>
> B. Cannot perform emergency surgery [even if one can do on-emergency, elective surgery]
>
> ____ NO ____ YES

Respondents who answered yes to either A or B were asked to estimate the "approximate prevalence" of jobs in the general economy of jobs for orthopedic surgeons with the specified limitations on their duties. The choices were "none to rare," "Occasional [< than 1/3 of all jobs in the economy]," and "Frequent [> than 2/3 of all jobs in the economy]."

First, as counsel pointed out to Reliance during the internal appeal phase, the survey does not mention the possibility that the orthopedic surgeon might not be able to work a forty-hour week. Reliance's in-house vocational expert opined that full-time employment was implicit in the question. This hardly obviates the problem, however, because the medical evidence suggesting that Dr. Lasser should not work full-time has never been squarely addressed by Reliance.

Reliance's analysis of the survey results is also troubling. In its letter affirming the denial of benefits, Reliance wrote that "the majority of respondents did acknowledge that the occupation can be performed on a full-time basis without on-call and emergency surgery duties." Actually, of the fourteen respondents to the e-mail survey, five answered "No" to both questions and three answered "Yes" to one or both questions, but estimated the prevalence of jobs with the listed limitations as "None or rare."[2] One respondent stated that any such practice would be limited to writing reports, an occupational activity clearly not equivalent to that of an orthopedic surgeon. Four respondents said that jobs for such a restricted orthopedic surgeon were "Occasional [< 1/3 of all jobs in the economy]" and one provided a narrative response that said such a practice "probably" could be arranged.

To characterize this as a "majority" of responses bolstering Reliance's assessment that Dr. Lasser was able to continue unimpaired in his occupation is flatly inaccurate. Indeed, it is difficult to discern what useful information may be gleaned from the survey. For example, while Reliance concedes that some respondents indicated that positions for Dr. Lasser were "rare," in fact one cannot tell whether the respondent meant that

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[2] The Court is relying upon the documents submitted by plaintiff, certified by counsel to be the actual responses to the survey. Reliance did not submit the raw data obtained by the survey.

jobs were rare, or actually "none." Finally, the limited number of responses, the lack of analysis of the geographical distribution of the respondents and the lack of any control or filter questions usually found in a professionally conducted survey, are obvious indicators that this survey is far from authoritative.

The Court finds in Reliance's treatment of Dr. Lasser's case a willingness to credit obviously questionable evidence that favor termination of benefits and a studied refusal to even address evidence that favors Dr. Lasser. At points, Reliance simply mis-states the evidentiary record in its benefits termination letters. These findings strongly suggest that uncritical deference to the fiduciary's denial of benefits would be error.

It is true that certain factors present in *Pinto* are not implicated here. For example, there is no clear-cut reversal of position as in the *Pinto* case. On the other hand, there are common features as well. For example, like in *Pinto,* the insurer has focused narrowly on the beneficiary's ability to perform, rejecting without explanation medical opinion that the beneficiary risks sudden, severe deterioration if full-time employment continues. *See* 214 F.3d at 394. More fundamentally, the flaws in the factual bases for Reliance's decision to terminate Dr. Lasser's benefits permit the inference that the insurer's decision was influenced by its inherent conflict of interest.

Therefore, following *Pinto*, the Court believes that a substantially more stringent level of arbitrary and capricious review must be applied to this matter. The *Pinto* Court found sufficient evidence of conflict to cause it to "examine the facts before the administrator with a high degree of scepticism." *Id.* Acknowledging the differences between *Pinto* and this case, and attempting to "approximately calibrate[ ] the intensity of * * * review to the intensity of the conflict," *id.* at 393, this Court believes that *Pinto*'s "high degree of scepticism" is

excessive. Indeed, the *Pinto* formulation appears to presume that the fiduciary erred, a presumption this Court is unwilling to engage in at this time. However, given this troubled record, it would be inappropriate to grant more than a minimal amount of deference to the administrator's resolution of the contested issues before it.

No pre-existing term of art accurately captures the amount of scrutiny with which the Court would examine the administrator's decision in this case. The Court would not reverse if it found the evidence to be in equipoise or that a bare preponderance of the evidence is contrary to the administrator's determination. If, however, a substantial body of the evidence in the administrative record favors Dr. Lasser and that evidence stands unrebutted, the "heightened arbitrary and capricious" review appropriate on the facts of this case may compel a different result. In that event, the Court must lessen the deference normally attributed to the administrator's decision, heighten the degree of scrutiny to match the degree of conflict, and, in all likelihood, reverse the decision below.

This level of scrutiny is not fixed in stone, however. The parties should be alert to the fact that the Court, *infra*, deems it inappropriate to rule on the extent of the administrator's conflict of interest as a matter of law.[3] Thus, at trial, the Court will consider all the evidence relevant to the degree of conflict and the resulting location on *Pinto*'s range of heightened arbitrary and capricious review, and the Court will render a plenary determination of those issues at that time. At this stage of the proceeding, the level of intrusiveness with which the Court will review the denial of benefits is still an open question. The facts that emerge may confirm the Court's view as already expressed. These facts may, however, move the Court either

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[3] The Court's holding on this point is, of course, confined to the facts of this case. The Court believes, however, that only in the rare exception will so fact-sensitive an issue as inherent conflict and resulting bias of an ERISA administrator be appropriate for summary judgment.

further along the scale towards *Pinto*'s "high degree of scepticism" or, assuming the problems already identified are satisfactorily explained, back towards a more deferential standard of review.

3. Application of the summary judgment standard

It should be clear that the above discussion has no direct bearing on the ultimate question in this matter. That issue, whether Reliance's decision was arbitrary and capricious (as flexibly applied) on the facts presented to it,[4] *id.* at 394 n.8, is of course distinct from fixing the appropriate level of heightened arbitrary and capricious review at the correct place on *Pinto's* sliding scale. The proper level of scrutiny being provisionally identified, the Court now applies this mode of analysis to the issue of whether summary judgment is appropriate.

At least two critical issues of fact were presented to the plan administrator considering Dr. Lasser's claim. First, what limitations on Dr. Lasser's professional activity are medically justified? Second, assuming these limitations are well-founded, are the duties for which Dr. Lasser is disabled non-material such that he can nonetheless function in the occupation of an orthopedic surgeon? Subsidiary to this second issue is the factual question: what tasks and duties are necessary components of the occupation of an orthopedic surgeon?

The cases cited by Reliance on this point, none of which is binding on this court, are readily distinguished. These either concern doctors who had substantial, administrative components to their occupations for which they were not disabled, or dealt with different policies. Significantly, none of these cases addressed a policy that provided for total disability benefits where the insured was disabled from performing only

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[4] The Court suggests that this phrase, which is copied verbatim from the November 8, 2000 Opinion should have removed any doubt regarding what evidence was to be considered when the Court makes its final determination of whether the denial of benefits was arbitrary and capricious.

some of the material tasks of his occupation. Nor do they compel as a matter of law the conclusion that emergency surgery and on-call duty either are or are not a material part of the occupation of an orthopedic surgeon. *Cf. Ames v. Provident Life & Accident Ins. Co.*, 942 F. Supp. 551, 557 (S.D. Fla. 1994) (refusing to grant J.N.O.V. where evidence existed both *pro* and *con* that inability to practice surgery constituted total disability for orthopedic surgeon), *aff'd*, 86 F.3d 1168 (11th Cir. 1996).

Assuredly, a court could find for either party when considering the administrator's resolution of these factual questions under the heightened standard of arbitrary and capricious review discussed. Clearly, as in *Pinto*, "a factfinder could conclude that Reliance Standard's decision to credit its doctors over [the beneficiary's doctors] was the result of self-dealing instead of the result of a trustee carefully exercising its fiduciary duties to grant [the beneficiary] the benefits due [him] under the insurance plan." *Id.* at 394. Having made this determination, the Court will not risk pre-judging the outcome of these issues by an extended discussion of the record. Review of the discussion above will disclose that parties have advanced to the Court some factual support for each of their positions on the underlying merits of the claim as well as on the extent to which the administrator's decision was tainted by his employer's self-interest. This observation alone merits the denial of summary judgment. Surely credibility determinations as to the medical evidence will have to be made by the trier of fact.

4. The scope of the record

The motion for clarification or reconsideration arose from counsel's professed uncertainty over the proper scope of discovery in this matter following the Court's previous Opinion. Plaintiff's counsel argued that plaintiff was entitled to discovery to prepare for a full-blown evidentiary trial on all the issues implicated by his claim, including those concerning his

disability and ability to practice his profession. Defendant objected, saying that the Court's review of the underlying merits of the plaintiff's claim should be limited to the record before the administrator. Consequently, according to defendant, no discovery on these issues is appropriate. After full consideration of the issue, the Court is satisfied that the breadth of discovery sought by the plaintiff is contrary to law.

The supplemental briefing by the parties has revealed the precise contours of the dispute. The parties agree that the Court is not limited to the record below in weighing the existence or extent of the conflict of interest and resulting possibility of bias of the administrator in deciding the claim. As discussed, this factual question must be answered to decide how intrusive the Court's examination of the administrator's decision will be under *Pinto*'s heightened arbitrary and capricious sliding scale of review. The disagreement is limited to whether the Court can consider (and the parties discover) evidence dehors the record on the substantive merits of Dr. Lasser's disability.

Where *de novo* review of an ERISA benefits decision is appropriate, the Third Circuit has clearly held that the district court "is not limited to the evidence before the Fund Administrator." *Luby v. Teamsters Health, Welfare & Pension Trust Funds,* 944 F.2d 1176, 1184-85 (3d Cir. 1991). In such a case, the court may hold a full trial *de novo*, although it is not required to do so. *Id.* at 1185. Expanding the record "is crucial in cases * * * where there is no evidentiary record to review." *Id.* Indeed, such review is not really a review of the prior decision at all; in reality it is a do-over of the entire proceeding. On the other hand, where the arbitrary and capricious standard controls, Court of Appeals has been equally clear that the reviewing court is limited to the record before the plan administrator. *Mitchell v. Eastman Kodak Co.,* 113 F.3d 433, 440 (3d Cir. 1997).

Pinto complicates the matter by teaching that in some circumstances the choice of the standard of review is not a

binary, either-or matter. Under *Pinto* the appropriate level of review lies somewhere on a "sliding scale" or a "range," beginning at true arbitrary-and-capricious deference to the administrator and ending at some very much more intrusive level of inquiry, in which the administrator's findings are treated to a "high degree of skepticism." 214 F.3d at 394. As the *Pinto* court itself admitted: "once 'factors' [*i.e.* factors suggesting a biased benefits decision] are introduced, arbitrary and capricious stops sounding like arbitrary and capricious and more like some form of intermediate scrutiny, which has no analogue in this field." 214 F.3d at 392. Plaintiff asks the Court to confront the possibility that the rule against considering evidence outside the record is likewise not a matter of black or white, but should be tempered to serve the level of scrutiny the Court deems appropriate in the particular case.

The Court is, however, convinced that the record should not be expanded when employing heightened arbitrary and capricious review under *Pinto*. *De novo* review of ERISA benefits determinations serves a different set of interests than even the most intrusive scrutiny under *Pinto*. The "sliding scale" does not slide all the way to *Luby*-style, *de novo* review. Even at the far end of the range, heightened arbitrary and capricious review is different in kind. Therefore, despite the more penetrating review the determination may receive, expanding the record by analogy to *Luby* would be wrong.

In an ERISA benefits case, if *de novo* review applies, a priori the plan administrator enjoyed no discretion and made benefits decisions on pain of error. An erroneous denial constitutes a direct breach of the benefits provisions of the plan, and review in this Court under ERISA goes straight to the question of entitlement. *See Bruch,* 489 U.S. at 112-13. In contrast, where the plan grants discretion to the administrator, the beneficiary is entitled only to insist that the administrator's authority be exercised within the bounds of the discretion granted. Because the focus is on the administrator's performance, *see* 2 Steven A.

Childress, *Federal Standards of Review* § 15.08 at 15-45 (3d ed., 1999), review is necessarily confined to the evidence before the administrator.

It follows that, where the plan beneficiary's rights are to a benefits determination untainted by a conflict of interest, then a review of the same evidentiary record by an unbiased decision-maker should restore the beneficiary to the *status quo ante*. As one court in this Circuit has reasoned, if the beneficiary had a fair opportunity to put evidence before the plan administrator, limiting the record on judicial review should result in no prejudice. *O'Sullivan v. Metropolitan Life Ins. Co.*, 114 F. Supp. 2d 303, 309-10 (D.N.J. 2000). As in conventional arbitrary and capricious review, the proper focus is on the performance of the administrator and the record should therefore be limited to that which was before the administrator when it made the decision.

Those district courts addressing the issue have reached the same conclusion, and held that they should not expand the record "on the historic facts that informed the administrator's decision" even though a conflict of interest may mandate a more intrusive review under *Pinto*. *Friess v. Reliance Standard Ins. Co.*, 122 F. Supp. 2d 566, 573 (E.D. Pa. 2000); *O'Sullivan v. Metropolitan Life Ins. Co.*, 114 F. Supp. 2d 303, 309-10 (D.N.J. 2000); *Ernest v. Plan Administrator of the Insured Benefits Plan*, 124 F. Supp. 2d 884 (M.D. Pa. 2000). Although Pinto itself is silent on whether the district court may consider new evidence on the underlying merits when applying heightened arbitrary and capricious review, *O'Sullivan*, 114 F. Supp. 2d at 309 n.6, the opinion of the Court of Appeals in *Pinto* may be read to suggest that the record should not be expanded.

In a footnote, the Court of Appeals stated:

> Our focus on process should not be read to require an additional duty to conduct a good faith reasonable

> investigation. That is, we are not holding that [the administrator] had a duty to gather more information, merely that the decision might have been arbitrary and capricious *given the information available.*

214 F.3d at 394 n.8 (emphasis added). Plainly heightened arbitrary and capricious review is still a review of the decision below. It is not a do-over of the administrative proceeding and thus qualitatively different from the *de novo* review contemplated by *Luby.*

Pinto's footnote eight poses another problem, however. If the administrator has no duty to investigate, it follows that the administrator has no duty to create a record upon which to rule and that the burden to do so and must fall solely on the beneficiary. This suggests that where the record before the administrator is insufficient to decide one way or the other regarding an entitlement to benefits, denial cannot have been arbitrary and capricious regardless of the grounds stated by the administrator. Of course, where there is sufficient evidence to permit a reasonable determination of the entitlement to benefits, there is no need to expand the record. *Pinto*'s footnote eight suggests that even where the administrative record was inadequate to make a ruling, the Court still should not go beyond the evidence before the administrator.

The Court is not sanguine that such an absolutist approach correctly reflects either the Third Circuit's view or the underlying purposes of the ERISA statute. This Court is well aware of the oft-repeated concern to focus the disposition of benefits disputes in the administrative process established by the plan, and to avoid judicial second-guessing to the extent possible. One hopes, of course, that the self-dealing administrator and the application of *Pinto* will be the exception. If so, the concerns of judicial efficiency and/or entanglement with the ERISA process will be less urgent. More to the point, if one assumes a biased and self-interested benefits administrator and an empty record on an important element of

the claim, refusing to consider additional evidence that may shed light on the merits of the claim raises real questions of fairness and of whether ERISA's statutory purpose is being served.

The Court has not yet ruled whether the administrative record in this matter is adequate or not. The Court has raised this issue to highlight the potential problem, and to suggest a solution should one be necessary. The Fourth Circuit permits a remand to the administrator where the record is inadequate to decide one way or the other whether the benefits determination was reasonable. *See Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 789 (4th Cir. 1995); *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 125 (4th Cir. 1994). As noted, a remand would appear to be inconsistent with *Pinto's* footnote eight where the evidentiary burden is on the beneficiary. However, in *Bernstein,* the Fourth Circuit remanded notwithstanding the fact that the administrator had the burden of proof on the evidentiary point at issue. 70 F.3d at 790.

Assuming symmetrical fairness, *Bernstein* suggests that the Fourth Circuit would not withhold a remand from either party on the ground that an insufficient record constitutes a mere failure of proof on the part of the burdened party. Of course, it would not offend the logic of *Pinto* to remand where the administrator's conflict of interest had led it manipulate the record to exclude evidence favorable to the beneficiary. The Third Circuit's refusal to impose upon the administrator a duty to investigate does not mean the Court of Appeals would protect an administrator's bad faith truncation of the record.

Likewise, where an administrator's arbitrary and capricious resolution of an antecedent factual issue has caused error at a later stage of the analysis, remand to permit a fuller development of the record might well be appropriate. In fact, remand is consistent with an established practice in arbitrary and capricious review of ERISA benefits decisions. *See, e.g.*, *Peterson v. Continental Cas. Co.*, 77 F. Supp. 2d 420, 429

(S.D.N.Y. 1999); *Sova v. Wheaton Franciscan Servs., Inc. v. Health & Welfare Benefit Trust,* 40 F. Supp. 2d 1031, 1042 (E.D.Wis. 1999).

Lastly, remand in the circumstances described above would go far to resolving the tension between limiting review to the administrative record and ensuring that ERISA benefits determinations retain a firm link to the objective merits of the beneficiary's claim. Therefore, despite *Pinto*'s footnote eight, and even though the Court agrees with defendant that the record before the Court on the underlying benefits determination must be limited to that which was before the administrator. The parties should be aware that remand is a procedural step to be considered in the Court's adjudication of this matter.

5. The nature of the trial to be held in this matter

For the foregoing reasons, the Court anticipates holding a trial on this matter at which it will accept whatever admissible evidence the parties may offer that is relevant to whether the benefits administrator acted under a conflict of interest. What standard of review should be applied to the administrator's determination as to the merits will be decided based upon the Court's assessment of the conflict evidence and the documentary evidence already part of the record of this matter.

Once the correct standard of review has been finally determined, whether the administrator's decision survives that review will be determined upon the administrative record. The Court does not agree with defendant's contention that because there is no dispute over the contents of this record, that summary judgment is appropriate. As the Ninth Circuit observed in *Kearney v. Standard Ins. Co.,* 175 F.3d 1084 (9th Cir. 1999), *cert. denied*, 528 U.S. 964 (1999), summary judgment on a fixed record and a plenary determination of fact, even on that same record, are different. With respect to its review of the administrator's decision, the Court anticipates adopting the procedure set forth in *Kearney* and making plenary

findings of fact pursuant to Federal Rule of Civil Procedure 52, even though no new evidence may be received on that branch of the case. Whether, as defendant further suggests, a hearing with oral arguments of counsel need be held as part of that Rule 52 proceeding, will be decided at a later date.

CONCLUSION

For the foregoing reasons, the application for leave to file a motion out of time to clarify or reconsider the Opinion and Order of November 8, 2000, will be granted. The Opinion and Order of November 8, 2000 will be vacated and replaced with this Opinion and the Order filed herewith.

The defendant's motion for summary judgment and plaintiff's cross-motion for summary judgment will be denied. Discovery in this matter shall proceed in a manner consistent with this Opinion, as follows:

1. The Court will permit discovery of evidence relevant to the existent or the extent that the decision regarding plaintiff's entitlement to benefits was affected by a conflict of interest or bias.

2. No discovery may be had of evidence relevant to issues underlying plaintiff's entitlement to benefits, such as for example, evidence relating to plaintiff's medical condition.

3. Evidence discoverable under the preceding paragraph 1, shall not be deemed non-discoverable on the ground that it is also included within the provisions of the preceding paragraph 2.

An appropriate Order is attached.

ORDER

In accordance with the Court's Revised Opinion filed herewith,

It is on this 8th day of February, 2001,

ORDERED that the application for leave to file a motion out of time to clarify or reconsider the Opinion and Order of November 8, 2000, is granted; and it is further

ORDERED that this Court's Opinion and Order of November 8, 2000 are vacated and replaced with the Revised Opinion and this Order; and it is further

ORDERED that the defendant's motion for summary judgment and plaintiff's cross-motion for summary judgment are denied; and it is further

ORDERED that discovery in this matter shall proceed in a manner consistent with the Revised Opinion, as follows:

1. The Court will permit discovery of evidence relevant to the existent or the extent that the decision regarding plaintiff's entitlement to benefits was affected by a conflict of interest or bias.

2. No discovery may be had of evidence relevant to issues underlying plaintiff's entitlement to benefits, such as for example, evidence relating to plaintiff's medical condition.

3. Evidence discoverable under the preceding paragraph 1, shall not be deemed non-discoverable on the ground that it is also included within the provisions of the preceding paragraph 2.

(2)

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No. 03-1203

IN THE

Supreme Court of the United States

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Petitioner,

v.

STEPHEN P. LASSER,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Whether, as this Court suggested in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), in an action under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461, a court may consider as a factor in conducting arbitrary-and-capricious review of an administrator's discretionary decision to deny benefits that the administrator is also the plan insurer and thus operates under a structural conflict of interest.

2. Whether, for purposes of all disability insurance policies subject to ERISA, a claimant's return to work out of economic necessity is, as a matter of law, dispositive evidence that the claimant is not disabled.

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INTRODUCTION

Petitioner, Reliance Standard Life Insurance Company ("Reliance"), has not presented any question that merits the Court's attention. Reliance argues that the Court should address the degree of deference to be afforded to an administrator of an ERISA-covered disability insurance plan which, because it also is the insurer under the plan, operates under a structural conflict of interest in making discretionary decisions on eligibility for benefits. Reliance did not raise this issue in the Third Circuit, however. Specifically, it did not challenge the district court's ruling, in light of the carrier's structural conflict, to accord it a "moderate degree of deference" (Pet. App. 42a) under an arbitrary-and-capricious standard of review. For this reason alone, the petition should be denied on the first question presented. This case is also a poor vehicle for deciding the standard-of-review question presented by Reliance. As the district court noted, it is "an academic exercise" (Pet. App. 74a) to decide what standard of review should apply here because Reliance's decision to deny Dr. Lasser's claim for disability benefits would be erroneous under any standard of review.

In any event, there is simply *no* conflict among the circuits on the standard-of-review question in this case. All of the courts of appeals to have addressed this question agree, consistent with this Court's statement in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), that a plan administrator's conflict of interest is a factor to be considered in conducting arbitrary-and-capricious review where the administrator's discretionary denial of benefits under the plan does not reflect any actual bias.

Reliance's second question presented is whether a claimant's return to work is, as a matter of law, dispositive of non-disability in all settings. The Court of Appeals rejected Reliance's argument for case-specific reasons, namely, that Dr. Lasser returned to work out of economic necessity, to the detriment of his health, and against medical advice. To

create the appearance of a circuit split, Reliance cites two decisions where the policy language at issue expressly provided that a claimant could not be deemed disabled if he was working. There is no such language in the policy at issue here. The cases offered by Reliance thus merely underscore the unremarkable proposition that courts look to policy-specific language and case-specific evidence of a claimant's disability in evaluating an insurer's determination against disability.

STATEMENT OF THE CASE

Dr. Lasser's Disability and Claim for Benefits

Dr. Lasser is an orthopedic surgeon who was employed by a four-doctor practice group in New Jersey. Pet. App. 5a. He has coronary artery disease and, due to a progression in his disease and a bypass surgery in 1986 that was improperly performed, suffered a heart attack in July 1996. *Id.* at 6a. After the heart attack, Dr. Lasser's treating physician advised him to reduce his work-related stress. *Id.* In accordance with this advice, Dr. Lasser returned to work in September 1996 on a reduced schedule. *Id.* He decreased his patient load by 50%, was no longer "on call" at night or on weekends, and did not perform emergency surgery. *Id.* As a result of his decreased work schedule, Dr. Lasser's compensation fell from approximately $26,000 per month to between $4,000 and $6,000 per month. *Id.* at 12a.[1]

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[1] Reliance states in its petition that a claimant is "disabled" under the policy, and thus entitled to disability benefits, "if he or she is not 'capable of performing the material duties of his/her regular occupation' on *a full-time basis*." Pet. 3 (emphasis added). This is *not* what the policy states. Under the policy, a claimant is considered totally disabled if he or she "is capable of performing the material duties of his/her regular occupation on a *part-time basis* or some of the material duties on a full-time basis." Pet. App. 42a (emphasis added). Dr. Lasser's return to part-time work in September 1996 thus did not render him ineligible for disability benefits under his policy.

Reliance had issued a long-term disability policy to Dr. Lasser's practice group. Pet. App. 5a-6a. Dr. Lasser made an application for long-term disability benefits under this policy. On December 26, 1996, Reliance initially granted the application, *id.* at 6a, but then changed its mind one year later, primarily in response to a medical evaluation by a Dr. William Burke hired by Reliance. *Id.* Dr. Burke concluded that Dr. Lasser was not disabled because he had performed well on a treadmill test and certain other physical tests. *Id.* at 15a; *see also id.* at 43a-44a. Dr. Burke's report did not, however, address the risks posed to Dr. Lasser by work-related stress, as identified by Dr. Lasser's treating physician. *Id.* at 43a-46a.

Dr. Lasser invoked Reliance's appeal procedure to challenge the carrier's termination of benefits. Pet. App. 6a. A total of five cardiologists other than Dr. Burke—including two whom Reliance itself had specifically retained after Dr. Lasser initiated his appeal—examined Dr. Lasser and concluded that due to his heart condition he should avoid work-related stress and, in particular, should not perform all of his customary duties as an orthopedic surgeon. *Id.* at 16a-19a; *see also id.* at 44a, 56a. Reliance nevertheless denied Dr. Lasser's administrative appeal and determined that Dr. Lasser was not "disabled" within the meaning of the policy. *Id.* at 7a.

Proceedings in the District Court

Dr. Lasser brought this lawsuit to challenge Reliance's denial of benefits to him under ERISA's private-action provision, which allows a beneficiary to sue for "benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). Pet. App. 7a. The parties made cross motions for summary judgment. *Id.* at 78a. The district court denied both motions. *Id.* at 103a-104a.

After a bench trial, the district court determined what standard of review to apply. Pet. App. 38a-42a. Finding that Reliance operated under a structural conflict of interest yet

exhibited no "overt bias" in denying Dr. Lasser's claim, the court ruled that the appropriate standard in this case was a modified form of arbitrary-and-capricious review under which Reliance was afforded a "moderate degree of deference." *Id.* at 42a.

The district court then held that Reliance abused its discretion by failing to provide a rational explanation for why it discounted the substantial weight of medical opinion—specifically, the opinions of Dr. Lasser's treating cardiologist and three other cardiologists—that Dr. Lasser could not return to full-time work without unduly increasing the risk of suffering another heart attack. Pet. App. 56a. Instead, in denying Dr. Lasser's claim, Reliance adhered to Dr. Burke's analysis, which concluded that Dr. Lasser had performed well on certain physical tests and therefore was not disabled. *Id.* at 43a-44a. As the district court noted, five other cardiologists who had examined Dr. Lasser pointed out that Burke failed to address the risk to Dr. Lasser's condition posed by occupational stress.[2] *Id.* at 44a-46a. The court found that Dr. Burke's fundamental error "infected Reliance's entire treatment of the case," which included using a classification system that measured a cardiac patient's capacity for exercise but did not address occupational stress. *Id.* at 46a-47a.

The district court ordered judgment for Dr. Lasser. It held that Reliance had not "furnish[ed] sufficient grounds to uphold [its] decision under the arbitrary and capricious standard." Pet. App. 76a. And, although the court had applied a "slightly less deferential standard" to Reliance's decision, it determined that the carrier's decision was "so

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[2] The other cardiologists also faulted Dr. Burke for using an unconventional stress test that was not widely accepted and which, in one cardiologist's view, "raise[d] a question about the qualifications of [Dr. Burke]." Pet. App. 44a. The district court also catalogued other key errors and omissions in Dr. Burke's analysis. *Id.* at 44a-45a.

wrong as to require reversal under any standard." *Id.* at 41a. Indeed, the court stated that its application of the sliding-scale approach to this case was, in the end, "an academic exercise" because, "even under its most deferential iteration, arbitrary and capricious review requires that the denial of Dr. Lasser's benefits be reversed." *Id.* at 74a; *see also id.* at 76a ("[E]ven under the regular arbitrary and capricious standard, the decision must be reversed.").

Proceedings in the Court of Appeals

On appeal, the Third Circuit affirmed. Pet. App. 5a. At the outset of its decision, it briefly discussed the standard of review applicable to this case. *Id.* at 8a-9a. The court noted that in cases, such as this one, where an insurer of an ERISA plan also operates as a claims administrator, "there is a structural or inherent conflict of interest that mandates a 'heightened' arbitrary and capricious review" under the *Pinto* decision. *Id.* at 8a (quoting *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000)). The Court of Appeals then summarized the district court's ruling that "the correct standard of review was 'at the mild end of the heightened arbitrary and capricious scale.'" *Id.* at 9a. The appeals court did not review this ruling, however, because, as it noted, "*[n]either party* disputes this conclusion on appeal." *Id.* (emphasis supplied).

The Court of Appeals reviewed Reliance's determination that Dr. Lasser was not disabled under the arbitrary-and-capricious standard. It recounted the principal evidence cited by Reliance—Dr. Burke's report—and noted that Dr. Burke opined, on the basis of a treadmill test and a physical examination, that Dr. Lasser did not "demonstrate any cardiovascular disability." Pet. App. 15a (quoting Dr. Burke's report). It then summarized the reports of the five other cardiologists who had evaluated Dr. Lasser, each of whom addressed the impact of stress on Dr. Lasser's heart condition—a factor that Dr. Burke's report did not address (*id.* at 43a-48a)—and concluded that Dr. Lasser should avoid

the stress of performing emergency and on-call duties. *Id.* at 16a-19a. On the basis of the record considered as a whole, the Third Circuit agreed with the trial court that Reliance acted arbitrarily and capriciously by disregarding the findings of every evaluating physician except Dr. Burke—that Dr. Lasser's heart condition precluded him from safely performing on-call and emergency surgery duties. *Id.* at 19a.

Judge Garth dissented from the majority decision on several grounds, but he did not disagree with the district court's articulation of the standard of review. Pet. App. 23a-24a. Indeed, Judge Garth noted that, if an insurer operates under a structural conflict of interest but there is no proof of actual bias—as the district court found here—then "the standard of deference to be employed would be 'deferential, but not absolutely deferential.'" *Id.* at 23a-24a (quoting *Pinto*, 214 F.3d at 393). Judge Garth believed, however, that the district court failed to adhere to this concededly "correct standard of review." *Id.* at 25a.

After the Third Circuit panel issued its decision, Reliance filed a petition for rehearing and petition for rehearing *en banc*. Significantly, Reliance's petition did not challenge the Third Circuit's determination to apply a somewhat heightened form of arbitrary-and-capricious review in this case. Indeed, Reliance embraced the Third Circuit's underlying *Pinto* approach when it asserted that the panel majority's opinion "conflict[ed] with the law of this Circuit regarding the manner in which the court should review a plan's decision under the heightened arbitrary and capricious standard" and was "inconsistent with [*Pinto*'s] heightened arbitrary and capricious standard of review." Respondent's Appendix ("Resp. App.") 2a. The Third Circuit denied Reliance's petition, with Judge Garth dissenting. Pet. App. 1a-4a.

REASONS FOR DENYING THE PETITION

I. THE COURT SHOULD NOT GRANT THE WRIT ON THE STANDARD-OF-REVIEW QUESTION

A. The Standard-of-Review Question Was Never Raised Below

The issue of what is the appropriate standard to use in reviewing Reliance's denial of disability benefits to Dr. Lasser was not raised by Reliance in its appeal or in its petition for rehearing, and nor was it reached by the Third Circuit. As a general rule, *certiorari* is not granted on questions raised for the first time in a petition to this Court. *See TRW Inc. v. Andrews*, 534 U.S. 19, 34 (2001) (refusing to reach issue that was "not raised or briefed below"). "It is this Court's practice to decline to review those issues neither pressed nor passed upon below." *FW/PBS, Inc. v. City of Dallas*, 493 U.S. 215, 224 (1990).[3]

This rule operates to preclude Reliance's petition here. After noting that the *Pinto* decision's sliding scale "might, in the appropriate case, slide all the way back to fully deferential arbitrary and capricious review," Pet. App. 39a, the district court held that it was inappropriate to apply "unmodified" arbitrary and capricious review where an insurer labored under "a true, structural conflict, even where other indicia of conflict or bias are absent." *Id.* at 40a-41a.

On appeal, Reliance did not challenge the district court's ruling to review the evidence with a "moderate degree of deference." Pet. App. 42a. The Third Circuit expressly

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[3] *See also City of Springfield v. Kibbe*, 480 U.S. 257, 259 (1987) ("We ordinarily will not decide questions not raised or litigated in the lower courts."); *EEOC v. Fed. Labor Relations Auth.*, 476 U.S. 19, 24 (1986) (noting the Court's "normal practice" to "refrain from addressing issues not raised in the Court of Appeals"); *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 147 n.2 (1970) ("Where issues are neither raised before nor considered by the Court of Appeals, this Court will not ordinarily consider them.").

observed that "*[n]either party* disputes this conclusion on appeal." *Id.* at 9a (emphasis added). And, in its rehearing *en banc* application, Reliance again did not argue that the district court chose the wrong standard of review and nor did it challenge the Third Circuit's sliding-scale approach first recognized by the *Pinto* panel decision. Reliance instead implicitly endorsed both *Pinto* and the district court's choice of standard. It argued that the majority opinion "conflicts with the law of *this Circuit*" and, citing *Pinto*, claimed that the majority opinion was "inconsistent with the heightened arbitrary and capricious standard of review." Resp. App. 2a (emphasis supplied).

Now, for the first time in the instant petition, Reliance seeks to raise an issue over the "choice of the appropriate standard of review" and says that that choice is "outcome-dispositive in this case." Pet. 15. As demonstrated below, resolution of this issue would make no difference to the outcome here. But, even if this issue mattered, Reliance has failed to preserve its ability to contest the choice of standard or review.

B. Resolution of the Standard-of-Review Question Would Make No Difference to the Outcome in This Case

A second reason this question is not cert-worthy is that the choice of standard of review would not affect the outcome here. The district court repeatedly stated that Reliance's denial of benefits to Dr. Lasser was erroneous and would require reversal even under an unmodified arbitrary and capricious standard. Pet. App. 41a ("[T]he denial of benefits was erroneous, and, indeed, so wrong as to require reversal *under any standard*.") (emphasis supplied); *id.* at 76a ("The Court believes that, even under the regular arbitrary and capricious standard, the decision must be reversed."). Indeed, the district court stated that it had been an "academic exercise" to determine the appropriate standard of review in this case because "*even under its most*

deferential iteration, arbitrary and capricious review requires that the denial of Dr. Lasser's benefits be reversed." *Id.* at 74a (emphasis supplied).

Because Reliance did not challenge the district court's choice of the standard of review, the Third Circuit assumed the denial of benefits was reviewable under the standard that the district court applied. Pet. App. 9a. But, as in the district court, whether the standard was garden-variety "arbitrary and capricious" or a somewhat heightened form of arbitrary-and-capricious review would not have made a difference to the result. The Court of Appeals held that Reliance's decision to deny benefits to Dr. Lasser was "arbitrary and capricious" and not supported by "substantial evidence," without itself referencing a heightened standard of arbitrary-and-capricious review. *Id.* at 15a, 21a. It would thus be, as the district court noted, an "academic exercise" for this Court to resolve the standard-of-review question presented in the petition.

Given this record, the premise of the petition is apparently not that the Court of Appeals used the wrong standard of review, but that it misapplied the concededly proper standard and "effectively applied *de novo* review." Pet. 1, 9; *see also id.* at 15. As an initial matter, Reliance is wrong; the Third Circuit properly applied the tenets of arbitrary-and-capricious review. Pet. App. 15a-19a (examining the "entire record to determine whether Reliance's determination is supported by substantial evidence"); *see also id.* at 21a.[4] In any event, Reliance must recognize that a petition complaining about the application of a proper standard to a particular state of facts is rarely granted. *See* S. Ct. R. 10 ("A petition for a writ of certiorari

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[4] The district court also properly invoked the principle of substantial-evidence review that a decision-maker may not adopt "what is so clearly the minority view [here, Dr. Burke's view] . . . without at least some rational explanation for doing so." Pet. App. 56a.

is rarely granted when the asserted error consists of . . . the misapplication of a properly stated rule of law."); *see also NLRB v. Hendricks Cty. Rural Elec. Membership Corp.*, 454 U.S. 170, 176 n.8 (1981) (questions of fact do not merit review by the Court); *Rudolph v. United States*, 370 U.S. 269, 270 (1962) (dismissing writ as improvidently granted where issue presented for review involved only the application of "clearly erroneous" standard of review).

C. There Is No Split Among the Courts of Appeals on the Standard-of-Review Question Presented by This Case

There is also no circuit split on the standard-of-review question identified (though not preserved) by Reliance. The question here is not, in general, what the standard of review should be in *any* action challenging a discretionary denial of benefits under an ERISA-covered plan when the administrator of the plan is also the insurer. Rather, the specific question as framed by the facts of this case is what the standard of review should be when an administrator's "structural" bias is not reflected by evidence of actual bias in its discretionary decision to deny benefits.

In this case, the district court expressly found that Reliance labored under a structural conflict of interest but that its claims administrator exhibited "no evidence of overt bias." Pet. App. 41a-42a. The courts of appeals are in full agreement as to what the appropriate standard of review should be in this circumstance: all circuits that have addressed the issue have held, consistent with this Court's statement in *Bruch*, that the administrator's determination should be reviewed under the arbitrary-and-capricious standard and that the administrator's inherent or structural conflict should be considered as a factor in conducting that review. *See generally Firestone*, 489 U.S. at 115 ("[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there

is an abuse of discretion.'") (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

In the First Circuit, all challenges to a conflicted administrator's decision are reviewed under the arbitrary-and-capricious standard, for which the "basic touchstone" is reasonableness. *See Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999). And, as part of this inquiry, courts are to consider whether an administrator of a plan who is also the insurer stands to lose money by paying a claim. *See id.* ("Any reviewing court is going to be aware that in the large, payment of claims costs [an insurer] money."). The Second Circuit's approach is in accord: when an administrator is also a plan insurer and there is no evidence that this structural conflict has actually influenced a discretionary benefits determination, the determination is reviewed for abuse of discretion but the conflict of interest is "a factor to be weighed 'in determining whether there has been an abuse of discretion.'" *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000) (quoting *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255 (2d Cir. 1996)).

Most of the courts of appeals—the Third, Fourth, Fifth, Eighth, and Tenth—use a "sliding scale" approach to determine the appropriate level of arbitrary-and-capricious review to afford discretionary benefits decisions made by a conflicted administrator. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Doe v. Group Hospitalization & Med. Svcs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Vega v. National Life Ins. Svcs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 (8th Cir. 1998); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826-27 (10th Cir. 1996).[5] Under this

[5] Reliance does not include the Eighth Circuit as among the courts of appeal that use a sliding-scale approach. Pet. 14. In *Woo*, however, the

approach, the administrator's structural conflict is one of several factors to be considered in shaping the scope of arbitrary-and-capricious review.[6] Though the sliding-scale approach is articulated differently than the approaches used in the First and Second Circuits, there is no difference in practical effect as applied to an administrator, such as Reliance here, whose structural conflict is not accompanied by independent evidence of actual bias. Under all of these approaches, the administrator's structural conflict of interest is simply a "factor" to be considered, alongside other case-specific factors, in conducting a review under the flexible arbitrary-and-capricious standard.

The remaining courts uniformly—and unsurprisingly—hold that an administrator's structural conflict of interest, standing alone, is a factor to be considered in an arbitrary-and-capricious review of a discretionary decision to deny benefits. The Sixth Circuit has held that an administrator's structural conflict of interest "'should be taken into account as a factor in determining whether the . . . decision was arbitrary and capricious.'" *Peruzzi v. Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998) (quoting *Davis v. Kentucky*

Eighth Circuit made clear that "[b]ased on our review of *Firestone*, we adopt the 'sliding scale' approach." 144 F.3d at 1161.

[6] *See Pinto*, 214 F.3d at 393 (sliding scale approach requires courts "to consider the nature and degree of apparent conflicts with a view to shaping their arbitrary and capricious review of the benefits determinations of discretionary decisionmakers"); *Doe*, 3 F.3d at 87 ("[A] conflict of interest environment is . . . a factor to be considered in determining whether authorized discretion has been abused."); *Vega*, 188 F.3d at 297 ("The existence of a conflict is a factor to be considered in determining whether the administrator abused its discretion in denying a claim."); *Chambers*, 100 F.3d at 827 (administrator's conflict is "merely a factor in applying this flexible [arbitrary and capricious] standard"); *see generally Woo*, 144 F.3d at 1161 ("The abuse of discretion standard is inherently flexible, which enables reviewing courts to simply adjust for the circumstances.").

Fin. Cos. Retirement Plans, 887 F.2d 689, 694 (6th Cir. 1989)); *Cochran v. Trans-General Life Ins. Co.*, 12 Fed. Appx. 277, 281 (6th Cir. 2001) (noting that the existence of a conflict "shapes application of" the arbitrary-and-capricious standard of review). The Seventh Circuit was the first court of appeals to articulate the notion of a sliding-scale of arbitrary-and-capricious review—the same standard used by the Third and most other circuit courts of appeals—and has used this approach to apply "careful" arbitrary-and-capricious review to a decision by an administrator who operated under a structural conflict of interest.[7] *See Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1988) (Posner, J.) (review under the sliding scale of arbitrary-and-capricious review is "more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is").

Admittedly, the Ninth Circuit—like the Second Circuit—conducts a *de novo* review when a claimant shows that an administrator's conflict of interest actually influenced its benefits determination. *See Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002), *rev'd on other grounds*, 123 S. Ct. 1965 (2003). But where, as here, there is no finding that the conflict has actually influenced an administrator's decision, the Ninth Circuit, like all of the

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[7] Reliance does not include the Seventh Circuit among the courts that use the sliding-scale approach. Pet. 13. But, as several other courts of appeals have noted—citing *Van Boxel* as authority—the Seventh Circuit also uses the sliding-scale approach. *See Fought v. UNUM Life Ins. Co.*, 357 F.3d 1173, 1181-82 (10th Cir. 2004); *Vega*, 188 F.3d at 296; *Travelers*, 167 F.3d at 57 n.2. Reliance cites to the Seventh Circuit's later panel decision in *Mers v. Marriott International Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), as indicating that the Seventh Circuit uses a different approach. At best for Reliance, however, *Mers* indicates only that the issue is still percolating in the Seventh Circuit. *But see Horwitz v. Alloy Auto. Co.*, 992 F.2d 100, 103 (7th Cir. 1993) ("not in the cards" for a later panel to overrule a prior panel decision).

other circuit courts including the Second Circuit, takes the structural conflict of interest into account when conducting a review under the arbitrary-and-capricious standard. *See Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 797 (9th Cir. 1997) ("Given [the insurer's] dual role as both the funding source and the administrator of the Plan, we are faced with an inherent conflict of interest situation, and must take this factor into account."). Finally, the Eleventh Circuit reviews an insurer's discretionary benefits determination under the arbitrary-and-capricious standard and allows this standard to be "shaped by the circumstances of the inherent conflict of interest." *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1563 (11th Cir. 1990); *see also Levinson v. Reliance Std. Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001) (arbitrary-and-capricious standard is "heightened" in reviewing discretionary determinations made by conflicted administrators in that the "standard 'must be contextually tailored' to the case") (quoting *Brown*, 898 F.2d at 1563-64).

Of course, not all courts of appeal articulate the standard using the exact same words. The administrator's structural conflict of interest is taken into account as a "factor," *see, e.g.*, *Pinto*, 214 F.3d at 392, *Doe*, 3 F.3d at 87; something that "shapes" the review, *see, e.g.*, *Cochran*, 12 Fed. Appx. at 281; to "adjust" for, *see, e.g.*, *Woo*, 144 F.3d at 1161; or to be "aware" of, *see, e.g.*, *Travelers Ins. Co.*, 167 F.3d at 57, when reviewing a discretionary determination that a claimant is ineligible for benefits and there is no evidence that the determination is tainted by bias. But these slight variations in phrasing all amount to the same fundamental approach. In *all* circuits, the administrator's structural conflict is treated as something that a court should consider, in conjunction with all of the other evidence, in determining whether the administrator's discretionary decision to deny benefits is arbitrary and capricious. There is no point in the Supreme Court taking this case to resolve a non-existent "conflict"

regarding what precise words should be used to describe what amounts to the same approach to conducting arbitrary-and-capricious review.

Reliance has strained to identify a conflict, but it has no bearing on this case. As noted, the courts of appeal use different approaches for determining what standard of review applies to an administrator's discretionary decision to deny disability benefits when—unlike in the present case—the administrator's conflict of interest is accompanied by proof that its decision reflected actual bias. *Compare, e.g., Sullivan*, 82 F.3d at 1256 (*de novo* review if evidence shows that administrator's decision was influenced by the conflict), *and Black & Decker*, 296 F.3d at 829 (same, if administrator cannot rebut the showing that conflict influenced its decision), *with Vega*, 188 F.3d at 296-97 (sliding scale). But that issue is simply not presented here. The district court expressly determined that Reliance did not exhibit any bias in denying Dr. Lasser's disability benefits claim. Pet. App. 41a-42a. Neither party challenged this determination on appeal, the Third Circuit did not review it (*id.* at 9a), and indeed Reliance would have no interest in *heightening* the standard of review. This case is thus not a suitable vehicle for determining the proper standard of review where an administrator's structural conflict of interest is accompanied by proof of actual bias.

II. THE CASE-SPECIFIC QUESTION OF WHETHER RETURNING TO WORK IS DISPOSITIVE EVIDENCE OF NON-DISABILITY IS ALSO NOT CERT-WORTHY

Reliance also urges review of "whether evidence that a claimant has returned to work may be taken into account in making disability determinations." Pet. 17. Reliance says that there is "tension" among the courts of appeals on this issue, but the differences in outcomes in the cases cited are attributable to straightforward, case-specific differences in the disability insurance policies at issue.

In this case, the Third Circuit rejected Reliance's argument that Dr. Lasser's return to work and resumption of on-call and emergency care duties "settles" whether he is disabled. Pet. App. 20a. Reliance cites two cases as "[c]ontrary to the Third Circuit's approach" (Pet. 17): *Galman v. Prudential Insurance Co.*, 254 F.3d 768 (8th Cir. 2001), and *Deegan v. Contintental Casualty Co.*, 167 F.3d 502 (9th Cir. 1999). Both cases turned on policy-specific definitions of "disability" which made it clear that a claimant could not be deemed disabled if she was working in any capacity. In *Galman*, a claimant who resumed working after suffering a heart attack could not claim he was disabled because the definition of "total disability" required that the claimant was "not working at any job." 254 F.3d at 771. Likewise, in *Deegan*, the policy defined "total disability" as, among other things, "not gainfully employed in any occupation for which [the insured] is or becomes qualified." 167 F.3d at 504. Given this language, the Ninth Circuit ruled that a claimant who had resumed full-time work was no longer eligible for disability benefits. *See id.* at 509.

Unlike the policies at issue in *Galman* and *Deegan*, the policy at issue here does not address whether an insured who returns to work may claim disability benefits.[8] The district court thus rejected Reliance's blunt argument that "[t]he fact [Dr. Lasser] was working proved that he was no longer disabled." Pet. App. 53a (quoting Reliance's brief). The court instead relied on case-specific evidence that Dr. Lasser was disabled due to his heart condition and that, although he had returned to on-call and emergency duties out of economic necessity, the added stress of performing these

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[8] An insured is deemed disabled under the policy at issue here if he "cannot perform the material duties of his[] regular occupation" as a result of an injury or sickness. An insured is also deemed disabled under the policy if he "is capable of performing the material duties of his[] regular occupation on a part-time basis or some of the material duties on a full-time basis." Pet. App. 42a.

duties posed an undue risk to his health. *Id.* at 54a. As noted, the Third Circuit agreed. *Id.* at 20a. The Court of Appeals likewise relied on the record evidence which showed that, to whatever extent Dr. Lasser had been performing on-call and emergency surgery duties, "he [was] doing so to his detriment" and against medical advice. *Id.* The Third Circuit's holding thus was not, as Reliance characterizes it, that "*as a matter of law*, an insurer may not consider evidence of a claimant's return to work in making an eligibility determination." Pet. 19 (emphasis in original). The Third Circuit instead determined only that, on the specific facts of this case, Reliance could not consider Dr. Lasser's return to work as dispositive evidence that he was not disabled.[9]

The circuit split that Reliance claims to have identified is thus illusory. Not surprisingly, none of the cases cited by Reliance holds that a claimant's return to work is, in the abstract, "dispositive" evidence that he is disabled. Each federal appellate court to have addressed the probative value of a claimant's return to work has done so on a case-by-case basis according to the particular terms of the disability

---

[9] The remaining cases cited by Reliance on this issue—*Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003), and *Levinson v. Reliance Standard Life Insurance Co.*, 245 F.3d 1321 (11th Cir. 2001)—do not stand for the proposition that a claimant's return to work is immaterial to a disability benefits determination. In *Hawkins*, the Seventh Circuit rejected the insurer's argument—similar to Reliance's argument here—that an insured's return to work means that, as a matter of law, "he cannot be disabled." 326 F.3d at 918. The only other case Reliance cites is the Eleventh Circuit's decision against Reliance in *Levinson v. Reliance Standard Life Insurance Co.* But, as Reliance concedes (Pet. 19), the Eleventh Circuit did not even reach the issue of whether an insurer may consider evidence of a claimant's return to work in making a disability determination because, as in this case, there was evidence that the claimant could not in fact perform the material duties of his job on a full-time basis. *See Levinson*, 245 F.3d at 1326 n.6.

insurance policy at issue and other, case-specific evidence of a claimant's disability. The issue is, at bottom, a case-by-case matter of construing disability insurance policy terms and evaluating all of the evidence of a claimant's disability. It does not merit this Court's attention.

CONCLUSION

The petition for a writ of certiorari should be denied in its entirety.

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April 23, 2004

APPENDIX

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

STEPHEN P. LASSER,	)	
	)	
Appellee,	)	
	)	
v.	)	**No. 02-4123**
	)	
RELIANCE STANDARD LIFE INSURANCE COMPANY,	)	
	)	
	)	
Appellant.	)	
	)	

APPELLANT'S PETITION FOR REHEARING
AND/OR REHEARING EN BANC

Statement of Counsel

I express a belief, based on a reasoned professional judgment, that the decision of the majority panel conflicts with a decision of the Supreme Court of the United States of America. Specifically, the majority panel held that "once a claimant makes a *prima facie* showing of disability through physicians' reports. . . , and if the insurer wishes to call into question the scientific basis of those reports. . . , then the burden will lie with the insurer to support the basis of its objection." See Opinion at p. 15. This statement is in direct conflict with the decision by the Supreme Court in *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003), wherein the Court held that "courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation."

The majority opinion also conflicts with the law of this Circuit regarding the manner in which the court should review a plan's decision under the heightened arbitrary and capricious standard. As stated in the dissenting opinion, "the majority discusses the evidence as if it was subjected to *de novo* review after trial. In doing so, it draws its own conclusion and substitutes its own judgment as to who and what is to be believed." See dissenting opinion at p. 24. This is inconsistent with the heightened arbitrary and capricious standard of review. *See Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377, 393 (3d Cir. 2000); *Orvosh v. Program of Group Ins. for Salaried Employees*, 222 F.3d 123, 129 (3d Cir. 2000).

/s/
Joshua Bachrach, Esquire

Introduction

On September 18, 2003, a majority panel of this court issued a Precedential Opinion affirming the decision of the district court in favor of the plaintiff. Dissenting from the majority's decision was Circuit Judge Garth. The underlying action involves a claim for disability benefits under an employee benefit plan that is governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq*.

Factual Background

Plaintiff-Appellee Stephen Lasser, M.D. is an orthopaedic surgeon. (JA 195). On July 16, 1996, Dr. Lasser developed chest pain and shortness of breath. (JA 195). He was subsequently diagnosed as having an acute myocardial infarction for which he underwent cardiac catheterization and stenting. (JA 205). A subsequent thallium stress test revealed that it was a "very small myocardial infarction" which the cardiologist described as "probably clinically insignificant." (JA 208).

Within a few weeks, Dr. Lasser had returned to work part-time, including office visits and elective surgery. (JA 209). His doctor told Reliance Standard that "by all objective criteria Dr. Lasser is doing very well at this point in time. He does not currently have symptoms." (JA 222).

None of the doctors who evaluated Dr. Lasser stated that he could not work full-time. Instead, his disability was based on his claim that he could not perform on-call or emergency services. Accordingly, Reliance Standard performed a vocational investigation to determine whether these were "material duties" of Dr. Lasser's occupation. Based on the results of the investigation, Reliance Standard concluded that they were not. (JA 235; 237). Dr. Lasser failed to submit any vocational evidence to contradict these findings. See Opinion at p. 23.

Based on its investigation, Reliance Standard concluded that Dr. Lasser was not totally disabled. Significantly, during Reliance Standard's adjudication of the claim, and contrary to his claimed disability, Dr. Lasser returned to his regular work schedule, *including* emergency services and on-call responsibilities. (JA 263).

Procedurally, this ERISA action was pending in the United States District Court for the District of New Jersey and assigned to the Honorable Alfred M. Wolin. Following the entry of a final order against it, Reliance Standard filed a timely appeal. On appeal Reliance Standard argued that:

> (1) Dr. Lasser cannot be considered disabled since he returned to his "regular" work; (2) the evidence did not support the conclusion of the district court that the denial of benefits was an abuse of discretion; and (3) the district court failed to properly apply the heightened arbitrary and capricious standard of review.

On April 24, 2003, oral argument was held before Chief Judge Scirica and Circuit Judges Ambro and Garth. On

September 18, 2003, the court issued a Precedential Opinion affirming the decision of the district court. The majority opinion was written by Judge Ambro in which he was joined by Chief Judge Scirica. A dissenting opinion was filed by Judge Garth.

Argument

A. The Majority Panel Adopted The "Treating Physician Rule" Contrary To The Decision of the Supreme Court in *Black & Decker Disability Plan v. Nord.*

On May 27, 2003, after oral argument was held in this case but prior to the filing of the Opinion, the Supreme Court issued its decision in *Black & Decker Disability Plan v. Nord*. At issue in *Nord* was whether the treating physician rule applies to disability claims under ERISA. Under the treating physician rule, ERISA plan fiduciaries were required to "accord special deference to the opinions of treating physicians." *Nord*, 123 S.Ct. at 1967.

The Court held that the treating physician rule may *not* be used in ERISA cases. Specifically, the court stated:

> . . . we hold, Courts have no warrant to require administrator automatically to accord special weight to the opinions of a claimant's physician; nor may Courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation.

Id.

In this case, the majority's discussion of "the burden of proof in disability cases" is in conflict with the law as stated in *Nord*. According to the majority, if the plan insurer does not accept the opinions stated in the claimant's physicians' reports, "then the burden will lie with the insurer to support the basis of its objection." See Opinion at p. 15. While the

court did not describe this as the treating physician rule, its effect is the exact same. The majority holding is contrary to the Supreme Court's admonition that courts may not impose on disability plans "a discrete burden of explanation" when they disagree with the opinion of a treating physician. *See Nord, supra.*

A sufficient basis for rehearing exists based on the conflict between the majority's decision and *Nord.* It is also worth noting, however, that the majority's decision also conflicts with the law of this Circuit. In *Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377, 394 n.8 (3d Cir. 2000), the Third Circuit emphasized that its discussion of the heightened arbitrary and capricious standard "should not be read to require an additional duty to conduct a good faith, reasonable investigation." *See also Foley v. Intern. Broth. Elec. Workers*, 271 F.3d 551, 559 n.9 (3d Cir. 2001)(claimant bears the burden of proof that the plan acted arbitrarily and capriciously).

B. The Majority Failed to Follow The Precedent of This Circuit in Its Analysis.

The dissenting opinion of Judge Garth correctly states the law to be followed by courts when reviewing a plan's decision under the arbitrary and capricious standard. Under this deferential standard, neither the district court nor the Court of Appeals may substitute its own judgment for that of the plan fiduciary. See Opinion at p. 18. *See also Abnathya v. Hoffmann-LaRoche, Inc.*, 2 F.3d 40, 41 (3d Cir. 1993). A decision is not arbitrary and capricious if there is evidence that might support the opposite conclusion. *Id.* A decision is only arbitrary if it is "clearly not supported by the evidence in the record." *Id. See also Orvosh*, 222 F.3d at 129.

As the majority concedes, the district court failed to follow the law of this Circuit when it relied on the Ninth Circuit's decision in *Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999), and made *de novo* findings of fact. See Opinion at p. 5 n. 3. However, according to the majority, the

district court's application of the incorrect law was not reversible error since the court limited itself to the evidence that was before Reliance Standard. *Id.* A court's review is not deferential simply because the court limits itself to the administrative record. In fact, the court in *Kearney* also limited itself to the administrative record when it conducted its *de novo* review of the claim decision.

As recognized by Judge Garth, the majority "has fallen into the same pattern of analysis employed by the District Court. Instead of addressing and assessing the basis, the rationale and the evidence which led to the Administrator's determination denying benefits, and then giving appropriate deference to that determination, the majority discusses the evidence as if it was subjected to *de novo* review after trial. In doing so, it draws its own conclusions and substitutes its own judgment as to who and what is to be believed." See Opinion at pp. 23-24. This type of analysis is not allowed under the law of this Circuit. *See Abnathya, supra.*

Contrary to the majority's conclusion, there is substantial evidence in this case supporting the denial of benefits. See dissenting opinion at p. 26. This evidence includes the fact that Dr. Lasser returned to full-time, unrestricted work, including on-call and emergency services while still claiming that he was disabled. (JA 263).

In its initial brief, Reliance Standard cited to several ERISA decisions in which courts found that disability plans properly denied benefit claims based on the claimant's demonstrated ability to work. *See Deegan v. Continental Casualty Co.*, 167 F.3d 502, 507 (9th Cir. 1999); *Galman v. Prudential Insurance Co. of America*, 254 F.3d 768 (8th Cir. 2001); *Davidson v. Liberty Mutual Insurance Co.*, 998 F. Supp. 1, 10 (D. Me. 1998); *Wesley v. Montsanto Co.*, 554 F. Supp. 93 (D. Mo. 1982), *aff'd*, 710 F.2d 490 (8th Cir. 1983).

In support of its conclusion that Dr. Lasser's return to work was not dispositive of his disability claim, the majority cites to two ERISA decisions which, upon review, do not

support that conclusion. In *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003), the claimant worked for a number of years with his condition before he claimed disability. The Seventh Circuit stated that the claimant may have forced himself to continue to work before the pain and fatigue became too much. *Hawkins*, 326 F.3d at 918. By contrast, Dr. Lasser returned to work while still claiming that he was still disabled. The claimant in *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321 (11th Cir. 2001) claimed that he had not returned to his prior full-time work while seeking benefits. Unlike these cases, the cases relied on by Reliance Standard are directly on point and dispositive of the claim.

The majority improperly substituted its own judgment for that of Reliance Standard when it dismissed the significance of Dr. Lasser's return to work. See Opinion at p. 16. In fact, the majority even questioned whether Dr. Lasser had returned to his prior job activities even though this was confirmed in the medical records. See Opinion at p. 16. Rather than deferring to Reliance Standard on this point as it was required to do under the law, the majority stated that "this issue involves a factual question that we do not resolve on appeal." This statement is inconsistent with the applicable law.

A major issue in this claim and on appeal was whether emergency and on-call work are material duties of Dr. Lasser's regular occupation. Supporting Reliance Standard's conclusion that these were not material duties were the DOT and a labor market survey. See Opinion at p. 22. As stated by Judge Garth, "[a]ll of this evidence stands unrebutted by Dr. Lasser." See Opinion at p. 23. Thus, Dr. Lasser failed to meet his burden since he "submitted no evidence, no proofs, no affidavits, no witnesses, and no depositions on the issue of materiality." See Opinion at p. 21.

The majority substituted its own judgment and "gave no deference whatsoever" to Reliance Standard in its review of

the vocational issues. See dissenting opinion at p. 22. Without any evidence offered by Dr. Lasser to contradict the DOT and the labor market survey, the majority nevertheless concluded that Reliance Standard abused its discretion. The majority stated that it was unreasonable for Reliance Standard to rely on the DOT since "the DOT's silence about this critical issue [of whether on-call and emergency services are material duties] makes the DOT unhelpful. . ." See Opinion at p. 9 n. 5. Contrary to this conclusion of the majority and the district court, the DOT only identifies material duties. Therefore, the fact that it does not include on-call and emergency services is substantial evidence that they are *not* material duties.

As stated in the dissent, and contrary to the majority's conclusion, the DOT "is a recognized authority in the vocational industry." See Opinion at p. 22 *citing Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 272-73 (4th Cir. 2002). *See also Dionida v. Reliance Standard Life Ins. Co.*, 50 F. Supp.2d 934, 939 (N.D. Cal. 1999). ("Given the amount of research and analysis that has gone into grouping similar jobs and defining the occupational titles, and the length of time the D.O.T. has been widely used, it is reasonable for plan administrators and courts to use it for determining a claimant's 'regular occupation"); *Winters v. Uum Life Insurance Co.*, 232 F. Supp. 2d 918, 931 (W.D. Wis. 2002) (referring to the Dictionary of Occupational Titles to define the claimant's occupation). When the majority disregarded the DOT when it was faced with no contrary evidence, it substituted its own judgment for that of Reliance Standard. This is improper under Third Circuit law.

The majority also substituted its own judgment for that of Reliance Standard by disregarding the results of the vocational study. As Judge Garth remarked, "the use of such vocational studies in eligibility for disability benefits is an accepted practice in this Circuit." See Opinion at p. 23, *citing Russell v. Paul Revere Life Ins. Co.*, 288 F.3d 78, 79 82 (3d

Cir. 2002). Contrary to the majority's conclusion and as stated by Judge Garth, it was not unreasonable for Reliance Standard to conclude that on-call and emergency services were not material based on the survey and the fact that Dr. Lasser failed to provide a contrary vocational opinion. *Id.*

According to the majority, "Dr. Lasser's regular occupation was as an orthopaedic surgeon responsible for emergency surgery and on-call duties in a relatively small practice group and within a reasonable travel distance from his home in New Jersey." See Opinion at p. 6. This was not Dr. Lasser's "regular occupation." Instead, this was his *job* and the Reliance Standard policy only pays a benefit when a claimant is unable to perform the duties of his "regular occupation," not his job. *See Ehrensaft v. Dimension Works Inc. Long Term Disability Plan*, 120 F.Supp.2d 1253, 1258-1259 (D. Nev. 2000)("the term, 'occupation,' is a general description, not a specific one. . . A person may not be able to perform a specific job assignment, but still be able to perform the duties generally understood to be part of his or her 'occupation.'); *Hanser v. Ralston Purina Co.*, 821 F. Supp. 473, 478 (E.D. Mich. 1993).

In support of its narrow interpretation of the term "regular occupation," the majority cites to *O'Bryhim v. Reliance Standard Life Ins. Co.*, 188 F.3d 502 (Table), 1999 W.L. 617891 (4th Cir. 1999). *O'Bryhim* is an unpublished decision and is no longer valid law in the Fourth Circuit. In the more recent published decision in *Gallagher* the Fourth Circuit stated that it was reasonable for Reliance Standard to rely on the DOT to define the material duties of the claimant's regular occupation. *See Gallagher*, 305 F.3d at 271. Of equal significance, the Fourth Circuit reached this conclusion while reviewing the plan's decision *de novo* whereas the majority in this case was required to give deference to the Reliance Standard.

The majority also relied on *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243 (2d Cir. 1999). *Kinstler*

also does not support such a narrow interpretation. *Kinstler* only required consideration of a position "of the same general character as the insured's previous job." *See Kintsler*, 181 F.3d at 252-253. More important, as recognized by Judge Garth but ignored by the majority, the court's review in *Kinstler* was *de novo* unlike this case. See Opinion at p. 24.

Contrary to the majority's holding, on-call and emergency services cannot be considered material duties of Dr. Lasser's regular occupation. Dr. Lasser's regular occupation involves performing orthopaedic surgery. Whether he performs these activities on-call or during regularly scheduled office hours, the duties are the same. Therefore, the time when these duties are performed cannot be considered a material duty itself. *See Ceasar v. Hartford Life and Accident Insurance Co.*, 947 F. Supp. 204, 207 (D. S.C. 1996)(plaintiff claiming he was disabled since his employer required rotating shifts which aggravated his sleep apnea was not entitled to benefits since a labor market survey found that the occupation could be performed for other employers without the requirement of rotating shifts); *Dym v. Provident Life and Accident Insurance Co.*, 19 F. Supp.2d 1147 (S. D. Cal. 1998) (gynecological surgeon whose prior practice involved on-call and emergency surgeries was not totally disabled even though he worked less hours following an accident).

The majority also relied on the decline in Dr. Lasser's earnings in support of its conclusion that on-call and emergency services were material duties. However, the majority admittedly guessed at what Dr. Lasser might earn if he worked forty hours per week. See Opinion at p. 9. The majority could only assume what Dr. Lasser might earn as there was no evidence in the record on this subject. This further demonstrates that the majority improperly arrived at its own factual conclusions rather than looking to whether Reliance Standard's decision was reasonable as it was required to do under the law.

Finally, the majority substituted its own judgment for that of Reliance Standard when it placed too great a weight on the potential risk of future harm due to stress from on-call and emergency services. This should not have even been a concern because, as stated by Judge Garth, by working unrestricted after disability benefits were discontinued, Dr. Lasser failed to satisfy "the policy's condition of inability to perform tasks material to his occupation. . ." See Opinion at p. 25.

In contrast to the majority's position, Judge Garth's conclusion is supported by ample case law. *See Galman v. Prudential Ins. Co. of America*, 254 F.3d 768 (8th Cir. 2001); *Gooden v. Provident Life & Acc. Ins. Co.*, 250 F.3d 329 (5th Cir. 2001); *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793 (8th Cir. 2002). In each of these cases, the claimants suffered from heart disease and their doctors stated that they risked further damage by returning to work. In each of these cases the courts concluded that it was not arbitrary and capricious to deny the claims since the claimants were currently capable of working. The facts in this case are even more compelling against a finding of disability since Dr. Lasser did return to work.

Judge Garth identified the real issue in this case and why Dr. Lasser should not prevail as follows:

> Reliance's policy does not insure against *future* disability, only *present* disability. A doctor or other expert who determines that a patient is disabled based on the possible *future* affects of stress should have to quantify that risk so that the ERISA decision maker can determine if it constitutes a present disability. Thus, an opinion that Dr. Lasser's venous graft may not survive another five years does not satisfy the condition of Reliance's disability policy, a policy which requires that Dr. Lasser be

> unable to perform the material duties of his occupation at this time.

See Opinion at pp. 26-27. Here, Dr. Lasser's doctors failed to even quantify the risk of future harm. See Opinion at p. 26. Once again, the majority substituted its own judgment for that of Reliance Standard when it stated that it was not necessary for the doctors to quantify the future risk. See Opinion at p. 15 n.12.

Based on the foregoing, Reliance Standard Life Insurance Company respectfully requests rehearing by the panel or in the alternative rehearing *en banc*.

By: /s/
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Supreme Court, U.S.
FILED
MAY 4 - 2004
OFFICE OF THE CLERK

No. 03-1203

In the Supreme Court of the United States

RELIANCE STANDARD LIFE INSURANCE COMPANY, PETITIONER

v.

STEPHEN P. LASSER

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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INTRODUCTION

In his brief in opposition, respondent offers no compelling justification for denying certiorari on either of the questions presented by this petition. As to the first question: perhaps recognizing the ultimate futility of arguing that there is no circuit split, respondent primarily contends that this case presents a poor vehicle, either because the question was not properly preserved below or because the resolution of the question would not be outcome-dispositive. Neither point has any merit. Where an earlier decision of the court below controls the outcome, this Court has never forced a petitioner to engage in the futile step of challenging that decision below before proceeding here. That approach makes even more sense where, as here, the petitioner is contending that the court below did not merely err by applying its prior rule, but instead effectively articulated a *new* rule, itself in conflict with the decisions of other circuits. Moreover, for the reasons given in the petition and in Judge Garth's dissent, there can be no doubt that resolution of the question presented *would* be outcome-dispositive in this case. The circuits are plainly split on the question, and, as *amicus* American Council of Life Insurers persuasively demonstrates, the question has significant implications for the review of benefit determinations across the whole range of ERISA-covered benefit plans, and indeed for the provision of benefits more generally. Certiorari on this question should therefore be granted.

As to the second question: respondent's sole contention is that the different outcomes in the courts of appeals on the use of evidence regarding a claimant's return to work can be chalked up to variations in the governing policy language. This is wishful thinking. Some of those decisions involve materially indistinguishable policy language, and others do not depend at all on the policy language at issue. Particularly in light of the need for uniformity among the circuits on ERISA questions, certiorari on this question should also be granted.

REASONS FOR GRANTING THE PETITION

A. THE THIRD CIRCUIT ERRED BY APPLYING AN INSUFFICIENTLY DEFERENTIAL STANDARD OF REVIEW TO THE INSURER'S ELIGIBILITY DETERMINATION.

1. Respondent first contends that Reliance failed to preserve "[t]he issue of what is the appropriate standard to use in reviewing Reliance's denial of disability benefits" in the Third Circuit, and therefore cannot raise it here. Opp. 7. That contention is meritless.

As a preliminary matter, respondent's contention fails because it misapprehends the fundamental distinction between *issues* and *arguments*. The ultimate *issue* presented here is whether the lower court correctly reversed Reliance's denial of benefits to Dr. Lasser. There is no question that Reliance presented that issue below, and that the Third Circuit passed on it. *See, e.g.*, Pet. 5a (noting that "Reliance * * * argues that the District Court improperly held arbitrary and capricious its determination that Stephen Lasser was not disabled"). Respondent is contending merely that Reliance did not present a specific *argument* pertaining to that issue: namely, that the "sliding scale" standard previously adopted by the Third Circuit in *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000), was insufficiently deferential to discretionary eligibility determinations by a conflicted administrator or fiduciary. It is axiomatic that once an *issue* is properly presented, "a party can make any *argument* in support of [its position]; parties are not limited to the precise arguments they made below." *Yee v. City of Escondido*, 503 U.S. 519, 534 (1992) (emphasis added); *see also Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 245 n.2 (2000) (same). Reliance is not raising a new issue here: instead, it is merely making an argument that was foreclosed below by settled circuit precedent.

Moreover, even if the argument that the "sliding scale" standard previously adopted by the Third Circuit was insufficiently deferential were somehow treated as a discrete "issue," this Court has never required a petitioner to preserve a challenge on an issue controlled by an earlier decision of the court below by going through the motions of challenging the decision in that court. In the Third Circuit, as elsewhere, a panel is barred from reconsidering the decision of a previous panel. *See, e.g.*, *Montgomery County v. MicroVote Corp.*, 175 F.3d 296, 300 (3d Cir. 1999).[1] This Court has routinely granted certiorari in cases in which the decision under review was controlled by an earlier decision, seemingly without regard to whether the decision was challenged in that court. *See, e.g.*, *United States v. Knight*, 534 U.S. 112, 116 (2001); *Carter v. United States*, 530 U.S. 255, 260 (2000); *Wright v. Universal Maritime Serv. Corp.*, 525 U.S. 70, 75 (1998). And that practice is entirely in accord with the general rule that this Court will grant review on issues that were "not pressed" below, provided they were "passed upon" by the lower court. *See, e.g.*, *United States v. Williams*, 504 U.S. 36, 41 (1992); *Virginia Bankshares, Inc. v. Sandberg*, 501 U.S. 1083, 1099 n.8 (1991); *Stevens v. Department of Treasury*, 500 U.S. 1, 8 (1991).

Finally, the very premise of respondent's argument—namely, that Reliance is contending that the "sliding scale" standard previously adopted by the Third Circuit was insufficiently deferential—is incorrect. In its petition, Reliance did not assert

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[1] Respondent implies that, even if Reliance were not required to challenge the Third Circuit's prevailing standard of review before the panel below, it should have done so in its petition for rehearing *en banc*. *See* Opp. 8. A party need not file a petition for rehearing *en banc*, however, before filing a petition for certiorari in this Court. *See* 28 U.S.C. § 2101(c); S. Ct. R. 13.3. Just as a party need not ordinarily raise an issue in a post-trial motion in order to preserve it for review by the court of appeals, so too is it true that a party need not raise an issue in a petition for rehearing *en banc* in order to preserve it for review by this Court.

that the "sliding scale" standard of review was necessarily inappropriate: instead, Reliance asserted only that the Third Circuit erred by effectively applying a *de novo* standard of review (in conflict both with its earlier decision in *Pinto* and with the decisions of other circuits), *see, e.g.*, Pet. 9, and that reversal would be appropriate under *any* more deferential standard of review (*including* the "sliding scale" standard of review adopted in *Pinto*), *see, e.g.*, *id.* at 15-16. Reliance could hardly be expected to have preserved its challenge to the Third Circuit's effectively *de novo* standard of review before the panel had even minted it, and Reliance plainly *did* preserve that challenge, to the extent it was necessary to do so, in its petition for rehearing *en banc*. *See, e.g.*, Opp. 5a. For all of these reasons, respondent's attempt to manufacture a vehicle problem should be rejected.

2. Respondent contends that certiorari should be denied because "the choice of standard of review would not affect the outcome here." *Id.* at 8. That contention likewise lacks merit.

Far from providing a reason for *denying* certiorari here, the facts of this case suggest that it would be a particularly *good* vehicle for consideration of the appropriate standard of review. In its decision, the Third Circuit simply reweighed the evidence before Reliance on whether Dr. Lasser was disabled under the terms of Reliance's policy, ultimately choosing to credit the opinions of two of Reliance's physicians over that of a third. *See* Pet. 15a-19a. Moreover, not one of the various objective diagnostic tests used to evaluate Dr. Lasser's condition suggested that he was disabled, as the majority itself conceded. *See id.* at 16a. Indeed, as Judge Garth noted in his dissent, the administrative record in this case was "replete with evidence" supporting Reliance's decision. *Id.* at 30a. It is therefore clear that, under a deferential standard of review, Reliance's decision to deny benefits would have been upheld.

In contending that the choice of the standard of review is irrelevant here, respondent relies heavily on dicta in the district

court's decision to the effect that Reliance's denial of benefits to Dr. Lasser would "'require reversal under any standard.'" Opp. 8 (quoting Pet. 41a) (emphasis omitted). Notably, however, the Third Circuit, in reviewing the district court's decision, made no such statement—even though the Third Circuit, after paying "lip service" to a deferential standard of review, Pet. 22a (Garth, J., dissenting), ended up affording no real deference at all. To the extent the Third Circuit effectively adopted a less deferential standard of review, it erred; to the extent the Third Circuit did apply (or should have applied) a more deferential standard of review, it should have reversed. In either event, this is not a case in which resolution of the question presented would have no effect on the ultimate outcome, and certiorari should therefore be granted.[2]

3. Respondent halfheartedly contends that, while the courts of appeals have not used the "exact same words" in articulating the standard of review for discretionary eligibility determinations by a conflicted ERISA administrator or fiduciary, no genuine circuit split exists on the issue. Opp. 14. Respondent is mistaken.

As a preliminary matter, respondent simply ignores the fact that the Court has recently, and expressly, left open this very question. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002). Respondent likewise ignores the statements of some of this Nation's most respected jurists, explicitly recognizing that the courts of appeals are divided on the issue. *See, e.g., Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000) (Becker, then-C.J.); *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (Boudin, J.).

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[2] Moreover, to the extent there is any doubt as to whether the resolution of the question presented would automatically be outcome-dispositive, that is no reason to deny certiorari. In cases involving the choice of a standard of review, this Court routinely remands for application of the selected standard. *See, e.g., Cooper Indus., Inc. v. Leatherman Tool Group, Inc.*, 532 U.S. 424, 443 (2001).

Instead, respondent seeks to downplay the obvious split in the circuits by redefining the question presented, suggesting that this case presents only the issue of the degree of deference owed to a discretionary eligibility determination by a conflicted administrator or fiduciary *when there is no actual evidence that the conflict affected the decision*. *See, e.g.*, Opp. 10. Even if the question presented could be so narrowed, the circuits would remain divided. As catalogued in the petition, *see* Pet. 12-15, the circuits fall into three categories, with the First, Second, Sixth, Seventh, and Ninth Circuits generally holding that the mere existence of a structural conflict is insufficient to justify applying a less deferential standard of review; the Fourth, Fifth, and Tenth Circuits employing a "sliding scale" standard, under which a more deferential standard of review would presumably apply in cases in which there is no actual evidence that the conflict affected the decision; and the Eighth and Eleventh Circuits seemingly holding that the mere existence of a structural conflict is *always* sufficient to justify applying a less deferential standard of review.

Confronted with this abundance of conflicting case law, respondent merely quibbles with the placement of particular circuits in these three categories. Respondent's characterization of the law in these circuits, however, varies from the merely disingenuous to the affirmatively inaccurate.

Seventh Circuit. Respondent contends that the Seventh Circuit has not held that the mere existence of a structural conflict is insufficient to justify applying a less deferential standard of review, but instead has applied a "sliding scale" standard. *See* Opp. 13. The Seventh Circuit has expressly stated, however, that "[t]he existence of a potential conflict is not enough" to justify applying a less deferential standard. *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998). Although the Seventh Circuit's earlier decision in *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048 (7th Cir.

1987), does discuss the "sliding scale" standard, the Seventh Circuit in *Mers* cited *Van Boxel* approvingly for the proposition that "we have *rejected* the theory that an inherent relational conflict is sufficient to alter the standard of review," 144 F.3d at 1020 (emphasis added). And in a decision released after the petition for certiorari in this case was filed, the Seventh Circuit, citing *Mers*, has reaffirmed that the full-fledged arbitrary-and-capricious standard of review applies absent material evidence that the conflict affected the insurer's decision: indeed, the Court noted that the more deferential standard of review applied "[u]nless an insurer or plan administrator pa[id] its staff more for denying claims than for granting them." *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 409 (7th Cir. 2004) (Easterbrook, J.).

Second Circuit. Respondent contends that the Second Circuit has suggested that the existence of a conflict is a factor to be weighed in determining whether there has been an abuse of discretion, even absent evidence that the conflict affected the decision to deny benefits. *See* Opp. 11 (quotation omitted). Specifically, respondent quotes the Second Circuit's decision in *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89 (2d Cir. 2000), for the proposition that a "[structural] conflict of interest is 'a factor to be weighed in determining whether there has been an abuse of discretion,'" Opp. 11 (quoting *Pulvers*, 210 F.3d at 92) (internal quotation omitted). The full quotation from *Pulvers*, however, actually states that "[t]he fact that UNUM served as both plan administrator and plan insurer, although a factor to be weighed 'in determining whether there has been an abuse of discretion,' *is alone insufficient as a matter of law to trigger stricter review*." 210 F.3d at 92 (emphasis added). And *Pulvers*, in turn, was quoting from the Second Circuit's earlier decision in *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251 (2d Cir. 1996), which stated in no uncertain terms that a claimant was entitled to a less deferential standard of review only if the claimant showed that "the administrator was *in fact* influenced by the conflict of interest," *id.* at 1256 (emphasis

added).

Ninth Circuit. As with the Second Circuit, respondent contends that the Ninth Circuit "takes the structural conflict of interest into account when conducting a review under the arbitrary-and-capricious standard," even absent evidence that the conflict affected the decision to deny benefits. Opp. 14. Again, however, in the very decision on which respondent relies, the Ninth Circuit expressly noted that "we must review the decisions of an apparently conflicted employer- or insurer-fiduciary under the traditional abuse of discretion standard *unless it appears that the conflict may have influenced the decision.*" *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech.*, 125 F.3d 794, 798 (9th Cir. 1997) (emphasis added). Notably, that holding is consistent with a wealth of other decisions from the Ninth Circuit, which make clear that a more deferential standard of review applies absent "material, probative evidence" that the conflict affected the decision. *See, e.g., Alford v. DCH Found. Group Long-Term Disability Plan*, 311 F.3d 955, 957 (9th Cir. 2002); *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 829 (9th Cir. 2002), *rev'd on other grounds*, 123 S. Ct. 1965 (2003); *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995).

Eighth Circuit. Finally, respondent contends that the Eighth Circuit does not hold that the mere existence of a structural conflict is *always* sufficient to justify applying a less deferential standard of review, but instead applies the "sliding scale" standard. To be sure, in *Woo v. Deluxe Corp.*, 144 F.3d 1157 (8th Cir. 1998), an Eighth Circuit panel did seemingly adopt the "sliding scale" standard, *see id.* at 1161. In an earlier decision, however, another Eighth Circuit panel seemingly rejected that approach, holding (in reliance on an earlier Eleventh Circuit decision, and over Judge Beam's dissent) that "a relationship that places an ERISA benefits plan administrator in perpetual conflict warrants a higher level of scrutiny." *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997)

(internal quotation omitted). At most, therefore, the Eighth Circuit's subsequent decision in *Woo* shows that there is an intracircuit conflict on the standard-of-review issue—not that the Eighth Circuit has definitively adopted the "sliding scale" standard. *Cf.* ACLI Br. 8-9 (discussing *Woo* and other cases).

4. Finally, respondent offers no answer to Reliance's contention that this issue is a recurring one of considerable significance. *See* Pet. 16. As *amicus* American Council of Life Insurers has demonstrated, the question of the appropriate degree of deference owed to discretionary eligibility determinations by a conflicted ERISA administrator or fiduciary arises in a variety of factual contexts—from decisions regarding coverage for health, disability, and life insurance, *see* ACLI Br. 10-11, to decisions regarding the availability and level of pension benefits, *see id.* at 11. And the ongoing uncertainty in the law on this question has increased the cost of providing benefits, and even created incentives for smaller employers not to provide benefits at all. *See id.* at 11-15. If allowed to stand, the Third Circuit's decision threatens to enable courts in that circuit, like courts in others, to substitute their own judgments for those of better-situated plan administrators and fiduciaries. In light of the disarray in the lower courts and the importance of this issue, this Court's review is warranted.

B. THE THIRD CIRCUIT ERRED BY REJECTING THE INSURER'S RELIANCE ON EVIDENCE THAT THE CLAIMANT HAD RETURNED TO WORK.

1. Respondent contends that certiorari should be denied on the question whether an insurer could properly consider evidence that the claimant had returned to work in denying benefits, on the ground that the conflicting court of appeals decisions involved different policy language. *See* Opp. 15-18. Contrary to respondent's suggestion, however, *see id.* at 16, the relevant policy language at issue in *Deegan v. Continental Casualty Co.*, 167 F.3d 502 (9th Cir. 1999), was almost

identical to that at issue here, with the policy defining a claimant as disabled if the claimant was "continuously unable to perform the substantial and material duties of his regular occupation," *id.* at 507; *cf.* Pet. 42a (defining a claimant as disabled if the claimant was not "capable of performing the material duties of his/her regular occupation" on a full-time basis). Similarly, in *Galman v. Prudential Insurance Co.*, 254 F.3d 768 (8th Cir. 2001), the Eighth Circuit considered a policy that defined "total disability" as "not working at any job," *id.* at 771. Respondent offers no explanation for why the definitions of "disability" at issue in those cases would mandate a different outcome from the definition at issue here. And respondent does not deny that those decisions that have refused to allow insurers to consider evidence of a return to work have done so seemingly without *any* regard to the pertinent policy language. *See Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914, 918 (7th Cir. 2003); *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 n.6 (11th Cir. 2001).

2. Again, respondent offers no answer to Reliance's contention that this issue is a recurring one of considerable significance. *See* Pet. 20. If allowed to stand, the Third Circuit's decision, like those of other circuits, will allow claimants to recover benefits as a *supplement* to their income—in contravention of the basic premise of long-term disability insurance, which is to provide benefits as a *replacement* for a claimant's regular income. Given the significant implications of this rule, and given the proliferation of court of appeals decisions addressing the issue in recent years, the Court's review is warranted on this question as well.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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IN THE

Supreme Court of the United States

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Petitioner,

v.

STEPHEN P. LASSER,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF OF *AMICUS CURIAE* THE AMERICAN COUNCIL OF LIFE INSURERS IN SUPPORT OF RELIANCE STANDARD LIFE INSURANCE COMPANY'S PETITION FOR A WRIT OF CERTIORARI

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INTEREST OF *AMICUS CURIAE*

The American Council of Life Insurers ("ACLI")[1] is the largest life insurance trade association in the United States, representing the interests of 368 member legal reserve life insurers operating in the United States. These 368 member companies account for 69 percent of life insurance premiums in the United States among legal reserve life insurance companies, 53 percent of disability income insurance premiums and 76 percent of annuity considerations. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of ERISA.

Of substantial concern to ACLI and its members is the ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review applicable to actions under ERISA alleging wrongful denial of benefits when an insurer, or any other administrator or fiduciary, is operating under a conflict of interest. This conflict is the subject of Question 1 of the petition of Reliance Standard Life Insurance Company ("petitioner") for a writ of certiorari. ACLI is uniquely positioned to explain the practical effects of this ongoing conflict upon employer-sponsored benefit plans, and hence the need for the Court to resolve this conflict.

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1. Pursuant to Rule 37.6, ACLI's counsel of record hereby certifies that this brief was authored in whole by Barnes & Thornburg LLP, and that no individual or entity other than amicus curiae ACLI has contributed monetarily to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

ACLI respectfully urges the Court to grant the petition with respect to its Question 1.[2] In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that a deferential standard of review applies in ERISA actions challenging denial of benefits where the benefit plan confers upon the administrator or fiduciary discretionary authority to determine eligibility for benefits or construe plan terms. In the 15 years since *Firestone* was decided, the lower federal courts have failed to develop a consistent approach to the standard of review where an administrator or fiduciary of the benefit plan, whether it be an insured or a self-funded plan, is operating under a conflict of interest. The result has been a widespread and deepening conflict among the circuit courts of appeals with respect to the degree of deference to be afforded in such circumstances. The various approaches adopted range from affording a high degree of deference to affording, as in the instant case, essentially no deference at all and applying a de facto *de novo* standard of review.

The standard of review in cases of conflicted administrators and fiduciaries concerns all insured plans and all self-funded and self-administered plans, and hence a large proportion of the large number of ERISA actions brought in federal court alleging wrongful denial of employee benefits. The existing disarray among the circuits is particularly problematic because it severely undermines Congress' key objective in enacting ERISA – to establish a "uniform administrative scheme" for ERISA-covered benefit plans and a uniform body of federal

2. ACLI addresses only Question 1 (the standard of review applicable to benefit determinations of conflicted administrators and fiduciaries) and expresses no opinion as to whether the petition should be granted with respect to Question 2.

common law for enforcement of such plans. *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1, 9 (1987). Congress sought to establish this uniformity as part of its effort to encourage employers to establish benefit plans by eliminating the difficulties presented by and increased costs resulting from a patchwork of conflicting state and local laws. The disarray among the circuits also undercuts another Congressional objective in enacting ERISA – providing an efficient, cost-effective enforcement scheme for the administration of benefit claim decisions.

As a practical matter, the lack of uniformity among the circuits on this issue also is problematic because the multitude of approaches taken by the circuits leaves plans that wish to retain a high degree of discretion in making claims decisions without any clear guidance as to how the plan should be structured so that discretion can be preserved. Indeed, the only fail-safe position for doing so would appear to be self-funding the plan and hiring an independent third party administrator to make benefit determinations. Although this may be an option for large employers, smaller employers are unlikely to have the necessary financial resources or infrastructure to self-fund a benefit plan.

REASONS FOR GRANTING THE PETITION

A. THE CIRCUIT COURTS OF APPEALS HAVE NOT RESOLVED THEIR CONFLICTING STANDARDS OF REVIEW IN THE CONTEXT OF CONFLICTED ADMINISTRATORS AND FIDUCIARIES.

In *Firestone,* this Court used analogy to the law of trusts to establish the standard of review applicable to actions challenging the denial of benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Recognizing that ERISA "abounds with the language and terminology of trust law," 489 U.S. at 110, this Court held that where the plan confers discretion upon a plan administrator or fiduciary, federal courts should review the claims decision only for an abuse of that discretion. *Id.* at 115.[3] In *Firestone*, the Third Circuit had held that a *de novo* standard of review should apply when the employer itself is the plan administrator because of "the lack of assurance of impartiality on the part of the employer." *Bruch v. Firestone Tire & Rubber Co.,* 828 F.2d 134, 137-145 (3d Cir. 1987). Because this Court rested its decision in *Firestone* upon trust law, and not a "concern for impartiality," the Court only briefly addressed in dictum the impact of a conflict of interest on a deferential standard of review. It noted that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an *abuse of discretion.*'" 489 U.S. at 115 (emphasis added) (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). This Court thus indicated that deference is still owed.

3. This is consistent with the principle of trust law that where a trust confers discretionary authority upon a trustee, courts will not interfere with the trustee's exercise of that discretion absent indication that the trustee has abused that discretion. Restatement (Second) of Trusts § 187 cmt. d (1959).

In the 15 years since *Firestone* was decided, however, the Court has not provided further guidance as to the manner in which deference is applied when a conflict of interest exists.

With the dearth of guidance from this Court, the lower courts have developed conflicting and confusing standards. Federal courts and commentators alike have noted the conflicting approaches of the various circuit courts of appeals. The confusion is such that the circuits do not even agree on what constitutes a conflict, let alone on what standard of review should apply when a conflict is present. Some circuits have held that the mere fact that an insurer both funds a plan and makes the benefits decisions under it constitutes an inherent conflict of interest. *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001). Others find that this is insufficient to establish an inherent conflict of interest. *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, at *2 (7th Cir. Mar. 2004) (most insurers are so well diversified that the decision in any one case has no perceptible effect on the bottom line; unless an insurer or administrator pays its staff more for denying claims than granting them, the people actually implementing benefit systems are impartial); *Perlman v. Swiss Bank Corp.*, 195 F.3d 975, 981 (7th Cir. 1999) (fact that plan insurer was also administrator did not amount to a conflict of interest because "[w]hen the administrator is a large corporation, the firm has a financial interest, but the award in any one case will have only a trivial effect on its operating results"). Still others find that this circumstance either may or may not amount to a conflict of interest. *Davolt v. Executive Comm. of O'Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000) (fact that the plan administrator is also the insurer may give rise to a conflict of interest, but assumption that such conflict exists is inappropriate).

As petitioner notes, the decisions of the various circuit courts of appeals defy easy classification. The Second, Sixth and Seventh Circuits essentially hold that the existence of a conflict of interest does not justify applying a less deferential standard of review unless there is evidence that the conflict in fact affected or tainted the benefit decision. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (claimant required to produce evidence that "the administrator was *in fact* influenced by" the alleged conflict of interest) (emphasis added)[4]; *Peruzzi v. Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998) (rejecting argument that a "less deferential" standard of review should apply where claimant failed to present evidence sufficient to establish that administrator was motivated by self-interest); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) (claimant must provide "specific evidence of actual bias" showing that there is "a significant conflict" before court will apply a less deferential standard of review).

The Ninth Circuit also holds that the mere existence of a conflict of interest is insufficient to alter the standard of review. In *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995), the Ninth Circuit held that the deferential "arbitrary and capricious" or "abuse of discretion" standard of review applies unless the claimant presents "material, probative evidence, *beyond the mere fact of the apparent conflict*, tending to show the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Id.* (emphasis added). If the claimant presents such evidence, however, the benefit determination is presumptively void, although the administrator

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4. If the claimant presents sufficient evidence that the conflict of interest affected the decision, the Second Circuit reviews the benefit determination *de novo*. *Sullivan*, 82 F.3d at 1255-56.

may rebut this presumption by producing evidence sufficient to establish that the same decision would have been made even absent the taint. If the plan fails to carry this burden, the decision is reviewed *de novo*. *Nord v. Black & Decker Disability Plan,* 296 F.3d 823, 829 (9th Cir. 2002), *rev'd on other grounds,* 538 U.S. 822 (2003).

The Eleventh Circuit essentially holds that claim determinations of a conflicted administrator or fiduciary automatically are subject to a less deferential standard of review, irrespective of whether there is any evidence that the conflict actually affected the benefit decision. *Brown v. Blue Cross & Blue Shield of Alabama, Inc.,* 898 F.2d 1556, 1565 (11th Cir. 1990) (where claimant demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its decision was not tainted by self-interest). Under the Eleventh Circuit's approach, the court first assesses whether the benefit determination is "wrong" from the perspective of a *de novo* review. *Levinson,* 245 F.3d at 1326. If so, the determination is considered arbitrary and capricious unless the conflicted administrator or fiduciary justifies the determination on the grounds of its benefit to the class of all plan participants and beneficiaries. *Id.*; *Brown,* 898 F.2d at 1566-67.

The Third, Fourth, Fifth and Tenth Circuits employ a "sliding scale" of deference, under which the reviewing court always applies the abuse of discretion standard, but the degree of deference varies inversely with the evidence establishing a conflict of interest. *Pinto v. Reliance Standard Life Ins. Co.,* 214 F.3d 377, 391 (3d Cir. 2000) (adopting a sliding scale approach); *Doe v. Group Hospitalization & Med. Servs.,* 3 F.3d 80, 87 (4th Cir. 1993) (deference shown to the benefit decision "will be lessened to the degree necessary to neutralize any

untoward influence resulting from the conflict"); *Vega v. National Life Ins. Servs. Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*) ("[t]he greater the evidence of a conflict on the part of the administrator, the less deferential [the] abuse of discretion standard will be"); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826 (10th Cir. 1996) (adopting a sliding scale approach).

As the Tenth Circuit recently observed, the circuits that have adopted the sliding scale approach provide no guidance as to "how much less" deference the reviewing court should afford the conflicted administrator. *Fought v. UNUM Life Ins. Co. of Am.*, 357 F.3d 1173, 1181 (10th Cir. 2004) (*per curiam*). Under the Tenth Circuit's version of the sliding scale approach, the court shifts the burden of proof to the conflicted administrator or fiduciary, who must establish that its decision was reasonable under the traditional arbitrary and capricious standard. Where a sufficiently severe conflict of interest exists, the court shows less deference to the administrator. *Id.* at 1183.

Although the Eighth Circuit previously indicated that it subscribed to the Eleventh Circuit's approach in *Brown*, *see Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997) (holding that the "perpetual conflict" which exists when an insurer administers benefits from its own plan warrants a *de novo* standard of review), it now appears to have settled upon the sliding scale approach, albeit a modified version. *Phillips-Foster v. UNUM Life Ins. Co. of Am.*, 302 F.3d 785, 795 (8th Cir. 2002) (following the sliding scale approach); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 (8th Cir. 1998) (explicitly adopting the sliding scale approach). Under the Eighth Circuit's variation, a sliding scale of deference is applied only if the claimant presents "material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach

of the plan administrator's fiduciary duty to [the claimant]." *Woo,* 144 F.3d at 1160, *quoted in Barnhart v. UNUM Life Ins. Co. of Am.,* 179 F.3d 583, 587-88 (8th Cir. 1999).

The First Circuit applies another test, assessing the "reasonableness" of the benefit determination in light of the context in which the decision was made. *Doe v. Travelers Ins. Co.,* 167 F.3d 53, 57 (1st Cir. 1999).

The trial court and Third Circuit decisions below exemplify further the confusion surrounding the applicable standard of review. Although the trial court ostensibly applied the "sliding scale" approach with a resulting "moderate level" of deference, the degree of deference shown to the benefit decision was so low as to be a de facto *de novo* review. *See* Pet. App. 25a-27a (Garth, J., dissenting). Moreover, given that the trial court concluded, after an evidentiary hearing, that the administrator was *not* affected by the inherent conflict of interest, there is no rationale for applying a less deferential standard of review.

B. THE CONFLICT AMONG THE CIRCUITS UNDERMINES BASIC ERISA POLICIES AND ADVERSELY AFFECTS EMPLOYEE BENEFIT PLANS.

1. The Standard Of Review Issue Affects a Large Proportion Of ERISA Litigation.

It is important for the efficient operation of employer-sponsored benefit plans covered by ERISA that this Court resolve the conflict among the circuits on the standard of review. Given the large number of plans that are either insured or both self-funded and self-administered, the question of the standard of review applicable to benefit determinations rendered by conflicted administrators and fiduciaries frequently arises. As this Court noted in *Firestone,* the decision regarding the

standard of review can be determinative of the outcome of the action. 489 U.S. at 115.

It also is important that the Court resolve this conflict because of the broad scope of the ERISA actions it affects. ERISA applies to a variety of employer-sponsored benefit plans, the most common of which are health benefit plans, disability income insurance plans, life insurance plans and pension plans. Disputes over the standard of review can affect virtually every aspect of a wide range of benefit decisions. A few examples are:

1) in the context of a health benefits plan, whether a particular medical treatment is medically necessary,[5] whether a particular condition qualifies as a preexisting condition,[6] and whether a particular medical treatment is experimental or otherwise is not covered by the plan;[7]

2) in the context of disability income insurance plans, whether the claimant is disabled as defined by the plan,[8] and whether any plan limitations on benefits are applicable to the claims (*e.g.*, limitations on mental or psychiatric illnesses);[9]

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5. *Doe v. Travelers Ins. Co.*, 167 F.3d at 58-59.

6. *Davolt*, 206 F.3d at 809; *Chambers*, 100 F.3d at 818.

7. *Peruzzi*, 137 F.3d at 433-35.

8. *Alford v. DCH Foundation Group Long Term Disability Plan*, 311 F.3d 955, 960 (9th Cir. 2002); *Levinson*, 245 F.3d at 1325-27; *Pinto*, 214 F.3d at 379.

9. *Cochran v. Trans-General Life Ins. Co.*, 12 Fed.Appx. 277, Nos. 99-2102, 99-2447, 2001 WL 392050 (6th Cir. Apr. 13, 2001); *Lang v. Long Term Disability Plan of Sponsor Applied Remote Tech. Inc.*, 125 F.3d 794, 799 (9th Cir. 1997).

3) in the context of life insurance plans, whether the insured's death was accidental;[10] and

4) in the context of pension plans, years of service credit and the level of pension benefits.[11]

The standard of review issue even arises in the context of the plan's determination whether a particular individual is an employee or beneficiary covered by the plan. *See Vega,* 188 F.3d at 291-292, 295-297.

2. The Circuit Conflict Undermines the National Uniform Regulation Intended by ERISA, and Consequently Increases the Cost to Employers of Providing Benefit Plans.

Conflicting interpretations of federal law are disfavored generally and they are particularly problematic in the ERISA context. The ongoing conflict and confusion with respect to the standard of review applicable to benefit decisions of conflicted administrators and fiduciaries undermines the core policies underlying ERISA. In enacting ERISA, Congress was mindful not only of the need to establish certain minimum standards to protect the rights of employees, but also of the fact that benefit plans are voluntary on the part of employers. H.R. Rep. No. 93-533, at 9 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4647. One of ERISA's bedrock purposes therefore is to encourage the formation of employee benefit plans. 29 U.S.C. § 1001b(c)(2). Congress accordingly sought to minimize disincentives to the

10. *Mers,* 144 F.3d at 1024; *Hung v. Guardian Life Ins. Co. of Am.,* 28 Fed.Appx. 268, No. 01-1696, 2002 WL 104234 (4th Cir. Jan. 28, 2002).

11. *Johannsen v. District No. 1— Pacific Coast Dist, MEBA Pension Plan,* 292 F.3d 159 (4th Cir. 2002).

establishment of such plans and to facilitate their establishment at a reasonable cost.

The basic thrust of ERISA is to avoid multiplicity of regulation in order to permit uniform national administration of employee benefit plans. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995). For 30 years, ERISA's uniform regulation of employee benefit plans has fostered and protected the development of a system that extends crucial employee benefits to a vast swath of the nation's working population. ERISA has encouraged employers to take on the challenge of sponsoring benefit plans to provide employees and other beneficiaries with substantial financial protection from the high cost of health care and the financial risk of a disabling illness or injury, and with financial security in retirement. A key component of ERISA's success in expanding and enhancing employee benefits is the protection it affords plan sponsors, which frequently have employees and operations in many states, from the burdens of having to comply with multiple regulatory regimes. As this Court has noted, conflicting requirements make benefit administration more difficult and inefficient. When inefficiencies or difficulties are introduced into the benefit administration system, employers may decide to reduce the level of benefits offered, or to cease offering the benefits entirely. *Fort Halifax Packing Co.*, 482 U.S. at 11.

The disruption to a uniform system of administration is no less problematic when the lack of uniformity stems from conflicting interpretations of federal law rather than from conflicting state laws and regulatory requirements. In either context, unless the most stringent of the conflicting requirements is adhered to, claims procedures must be tailored to the particular jurisdiction in which the claim arises. Both situations increase the cost of providing benefits for all participants.

Moreover, due to the conflict on the standard of review issue, there is no clear guidance as to how claims processing should be structured so that plans can successfully retain a high degree of discretion in making claims decisions. Is it sufficient to have the funding and decision-making functions performed by different departments? Can a so-called "Chinese wall" be used to preserve discretion? Will discretion be preserved if a subsidiary or affiliate handles the benefits decisions?

3. The Circuit Conflict Undermines ERISA's Civil Enforcement Scheme, Increasing Litigation and Further Increasing the Cost to Employers of Providing Benefit Plans.

Another essential part of ERISA's statutory scheme is its "carefully integrated" civil enforcement scheme, which this Court has described as "one of the essential tools for accomplishing the stated purposes of ERISA." *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 137 (1990), *citing Pilot Life Ins. Co. v Dedeaux,* 481 U.S. 41, 52, 54 (1987). The primary goal of this scheme is "to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously." *Taft v. Equitable Life Assur. Soc.,* 9 F.3d 1469, 1472 (9th Cir. 1993). Under an abuse of discretion standard of review, the admissible evidence is limited to the administrative record, which consists of the insurance policy or plan document and claim file. Costly discovery of additional evidence (e.g., document requests, depositions, expert witness fees and reports) is either prohibited, unnecessary or severely limited. Because admissible evidence is typically limited to documents contained in the administrative record, ERISA lawsuits can be resolved promptly through dispositive motions by allowing the reviewing court to focus on the issue of whether the claim determination was reasonable and supported by substantial evidence. ERISA

litigation typically is resolved quickly and without the opportunity for attorneys from both sides to generate large amounts of discovery and to engage in costly and unnecessary activity. This relatively inexpensive method of litigation inures to the benefit of all plan participants by helping to maintain the costs for providing employee benefits at a reasonable level.

The current conflict and confusion among the circuit courts of appeals regarding the standard of review applicable to decisions of conflicted administrators and fiduciaries undermines this purpose by rendering ERISA's enforcement mechanism more costly in terms of both time and financial resources. Because of the ongoing uncertainty on this issue, the applicable standard of review for a conflicted decision maker is frequently litigated in ERISA actions. Indeed, the trial court below held a hearing just to determine the applicable standard of review. This causes parties to spend additional time and money in litigation. The uncertainty also generates additional litigation because the parties are less able to assess how the benefit determination will be viewed by reviewing courts.

4. The Circuit Conflict Negatively Impacts Benefit Plans and Employers In Additional Ways.

The conflict and confusion surrounding the applicable standard of review has additional negative consequences for benefit plans, whether insured or self-funded. The conflict creates an incentive for employers who desire a high degree of deference in their benefit plans to leave the insurance market or simply not offer the benefit plan. There essentially are three basic options in structuring a benefit plan: 1) insure the plan, 2) self-fund and self-administer the plan, or 3) self-fund the plan but hire an independent third party administrator to administer benefit claims. Under the current patchwork of federal decisions, the only fail-safe means of ensuring a high

degree of deference appears to be the third option — structuring the plan so that separate entities fund and administer the plan. Although self-funding and retaining a third party administrator may be an option for large employers, smaller employers are unlikely to have the necessary financial resources or infrastructure to self-fund a benefit plan. These smaller employers who have no alternative to funding a benefit plan through the purchase of insurance may end up bearing not only the increased cost resulting from an uncertain standard of review, but also increased costs stemming from a flight of larger employers from the insurance market. As a result, smaller employers in particular may choose either to offer a reduced level of benefits, or not to offer benefit plans at all.

C. A HIGHLY DEFERENTIAL STANDARD OF REVIEW SHOULD APPLY UNLESS THE CLAIMANT PRESENTS EVIDENCE THAT A CONFLICT OF INTEREST IN FACT INFLUENCED THE BENEFIT DETERMINATION.

ACLI respectfully submits that benefit determinations rendered by administrators or fiduciaries who are afforded discretion by the terms of the benefit plan but are operating under an alleged conflict of interest should be reviewed under a highly deferential standard of review unless the claimant produces signficant evidence that the conflict in fact affected the benefit determination. When the alleged conflict of interest does not in fact affect the benefit determination, the conflict essentially is a non-factor. Consequently, there is no persuasive reason why the benefit determination should be reviewed under a standard of review that is any less deferential than that applied to a non-conflicted administrator or fiduciary.

The circuit courts of appeals that have adopted the "presumptively void" and the "sliding scale" approaches essentially determine the standard of review based on who the administrator or fiduciary is, rather than whether a potential conflict actually influenced the benefit decision. As this Court determined in *Firestone,* the appropriate standard of review under ERISA derives from trust law, and not a concern for impartiality. 489 U.S. at 115. Indeed, ERISA permits entities with a conflict of interest to nevertheless act as administrators or fiduciaries. 29 U.S.C. § 1108(c)(3). When the benefit plan grants such entities discretion to make benefit determinations, federal courts should not negate the grant of discretion by altering the standard of review based merely on the potential for a conflict of interest. Moreover, the sliding scale approach creates the danger that that the outcome will be strongly influenced by the sympathetic facts of a particular case.

These approaches also undervalue the role that deference plays in the formation of benefit plans. Upholding a plan's grant of discretionary authority through application of a deferential standard of review provides plan sponsors with a degree of control over the benefit plan and promotes its affordability. As this Court has noted, ERISA does not mandate what, if any, benefits an employer must provide and employers have large leeway to design their plans. *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 833 (2003). Plans therefore have a legitimate interest in retaining discretion to interpret the terms of the plan and to render benefit decisions. Given the enormously wide range of issues that can arise in rendering benefit decisions under any plan, it is not possible to predict every type of issue and claim that may arise. Moreover, all plans have some terms that are arguably ambiguous as applied to peculiar facts. Discretion and a deferential standard of review enable the plan to resolve such issues in a manner that best protects the interests of all participants in the plan.

Absent evidence that a conflict in fact affected a benefit determination, application of a deferential standard of review provides adequate protection for the interests of the claimants under benefit plans. As Judge Easterbrook recently wrote for the Seventh Circuit, an employer

> has no reason to deceive its employees about the quality of fringe benefits on offer; that would just besmirch its reputation and make it harder to hire good people in competition with other [employers]. One might as well say that because a health maintenance organization has an incentive to skimp on care (for it does not collect extra fees for additional medical services), the judiciary must intervene to force HMOs to offer more or better care than they have promised by contract. Yet the Supreme Court held in *Pegram v. Herdrich*, 530 U.S. 211, 147 L. Ed. 2d 164, 120 S. Ct. 2143 (2000), that HMOs' well-known incentive to shave the costs of care does not justify "correction" under the banner of ERISA. The choice between fee-for-service and HMO-style incentives, neither of them perfect, is left to employers who must compete for good workers using a combination of salary and fringe benefits.

Leipzig, 362 F.3d 406, at *1. Similarly with respect to benefit claims decisions by insurers under insured plans, the Seventh Circuit previously explained that:

> [I]t is a poor business decision [for an insurer] to resist paying meritorious claims for benefits. Companies . . . that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans. . . . [These employers] want their employees satisfied with their

> fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers.

Mers, 144 F.3d at 1021. In sum, the assumption implicitly underlying the "presumptively void" and "sliding scale" approaches — that self-interested administrators and fiduciaries are motivated to deny valid claims — is not correct.

CONCLUSION

ACLI respectfully requests that the Court grant Reliance Standard Life Insurance Company's petition for a writ of certiorari with respect to Question 1 of the petition.

Respectfully submitted,

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